Canadian Hospital

- *Treating Communicable Diseases in The General Hospital*
- *Hospital Insurance in British Columbia*
- *Canadian Honoured at A.C.H.A. Convocation*

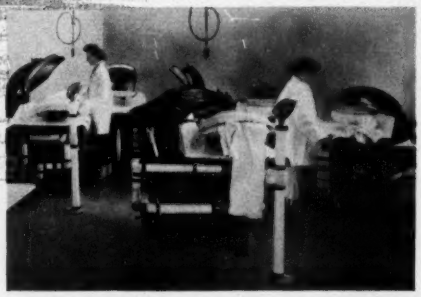
October, 1952

Official Journal—Canadian Hospital Council

3 HOSPITALS served by...

In modernized laundry at Kitchener-Waterloo Hospital, automatic controls for three CASCADE Unloading Washers (above) perform all operations of the entire washing cycle without any attention from the washman. By merely pushing buttons, Washers are then automatically unloaded into containers, which are lifted into and out of NOTRUX Extractor (background) by push-button-operated hoist.

TRUMATIC Folder on 8-Roll SYLON Flatwork Ironer (above) automatically quarter-folds large linens, with only one receiving operator needed to crossfold and stack work.



Hospital uniforms and other garments are neatly and quickly machine-ironed on these push-button operated Press Units.

KITCHENER-WATERLOO HOSPITAL, Kitchener, Ont., as part of a 2¼ million dollar expansion program, included a new laundry with modern, high-production equipment. This modernized laundry not only does all work for 500-bed Kitchener-Waterloo Hospital, but also for two other hospitals . . . 300-bed Guelph General Hospital, 18 miles away, and 200-bed Galt General Hospital, 11 miles away. In addition, the laundry does towels and other work for three municipally owned swimming pools and the Municipal Golf Club.

All this work is processed in a 44-hour week, and with the large volume making it possible to take advantage of high-production equipment, the net cost for all work laundered is *only 1.8¢ per pound.*

We of Canadian Laundry Machinery Co. are very proud to have been chosen to completely equip Kitchener-Waterloo Hospital's new laundry. We are proud of the confidence placed in us when we were delegated to make a thorough survey of the anticipated laundry load, prepare a floor plan layout for the laundry, and work with the architect for the expansion program.

Our Company offers this advisory and planning service to hospitals of every size and type, without cost or obligation. Our Hospital Laundry Consultant will welcome the opportunity to lend every assistance in planning a new laundry department, or modernizing your present laundry to increase its productive capacity. Just write for our Hospital Laundry Consultant to call.

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HOSPITAL GARMENTS

Contents

Vol. 29 **October, 1952** No. 10

(For Subscription Rates see page 90)

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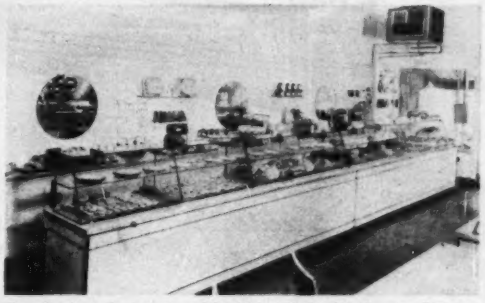
Hunt's Limited, whose slogan "The Better Kind" is a well-known "buy-word" for good candies, ice cream, baked goods and restaurant service, bought their first Frigidaire equipment thirty years ago. Their Frigidaire installations today include ice cream cabinets, delicatessen counters, soda fountain and back bar refrigeration and air conditioning.

Hunt's lay greatest stress on their Frigidaire Air Conditioning. "We don't think of building a store now without air conditioning", they say. "Air conditioning keeps our cream goods from souring, our chocolates from turning grey, our hard candy from becoming sticky.

"We have had people tell us they like to shop in our stores because of the air-conditioned comfort. We know that our girls work more efficiently, with less fatigue, because of our Frigidaire Air Conditioning."

One of the thirty-six Hunt's Limited stores in Toronto — this one, air conditioned by Frigidaire, is on north Yonge Street at Eglinton Avenue. Circle Refrigeration Limited handle Frigidaire sales and service to Hunt's Limited in the Toronto area.



View showing cake counter and Frigidaire Air Conditioning installation at front of 322 Bloor Street West store in Toronto.

Interior of Yonge & Eglinton store in Toronto showing candy counter at left, baked goods counter at right and Frigidaire-refrigerated delicatessen counter and Frigidaire Ice Cream Cabinet at rear.

Frigidaire-refrigerated soda fountain and back bar at Hunt's Limited store at 322 Bloor Street West in Toronto. Air Conditioning vents visible at rear.

Why not bring to your business the advantages that Hunt's Limited have found in Frigidaire equipment? What Frigidaire will do for you can be shown by a simple Frigidaire Refrigeration Security Analysis which any Frigidaire dealer listed below will give you absolutely without obligation. It may show that your *present* equipment is entirely adequate — or needs only some small attention such as a compressor overhaul. Find out now.

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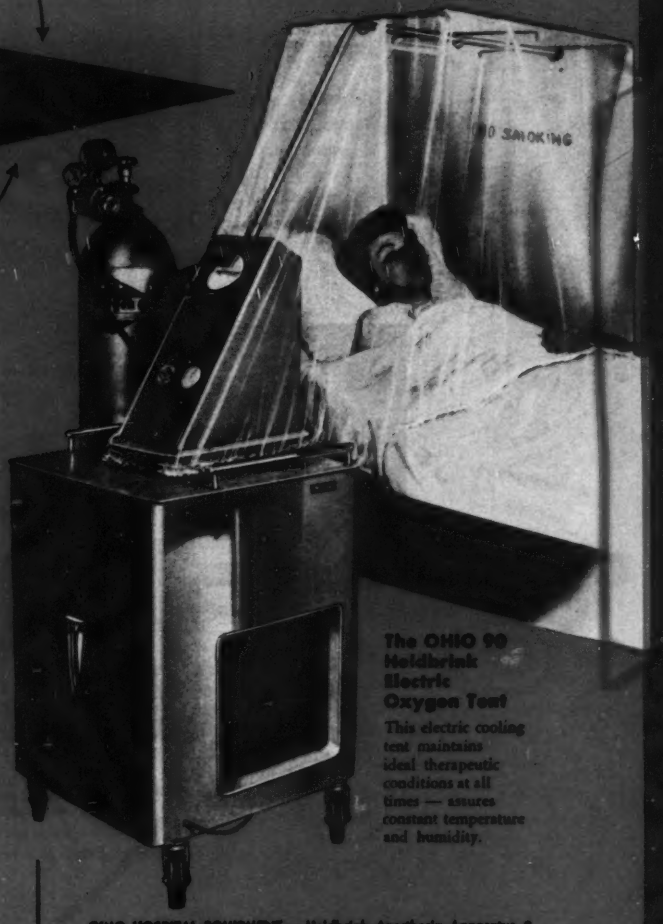

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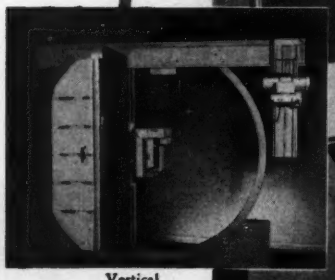
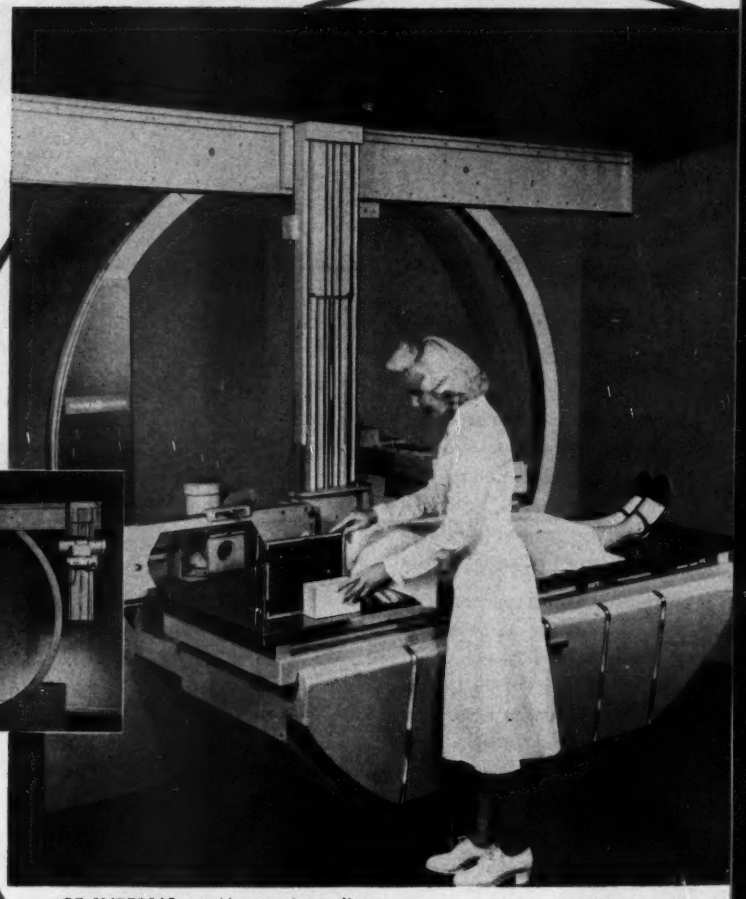
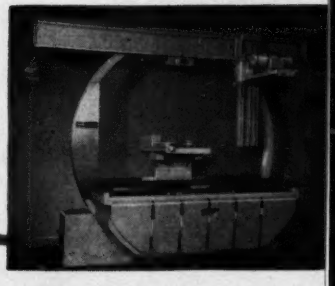


Vertical



GE IMPERIAL provides complete radiographic facilities in addition to the vast range of fluoroscopic positions, four of which are shown around the circle.

Horizontal



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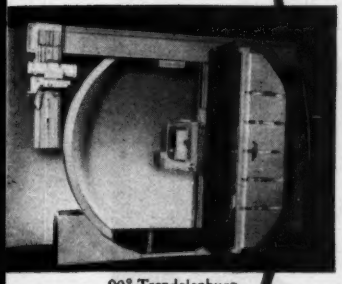
a revolutionary, new diagnostic x-ray unit

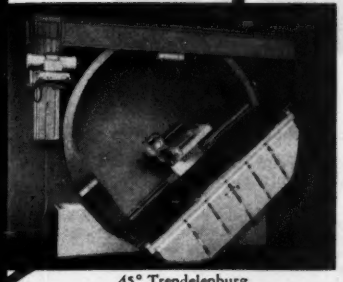
Brings undreamed of ease and facility to both fluoroscopy and radiography

A completely new concept of design — the new GE IMPERIAL is a great advance in diagnostic x-ray apparatus. It makes all fluoroscopic and radiographic technics easier and faster — even the most advanced and highly specialized procedures.

Check the partial list of exclusive advantages below. Then, for detailed information on the revolutionary, new GE IMPERIAL, call your GE x-ray representative. Phone or write the nearest office of General Electric X-Ray Corporation, Limited — Montreal, Toronto, Vancouver, Winnipeg.



90° Trendelenburg



45° Trendelenburg

Only GE IMPERIAL gives you all these features

1. **180° uninterrupted table angulation** — from 90° vertical to 90° Trendelenburg — with automatic, selective stop-over at horizontal only when desired.
2. **Operator-controlled speed of angulation through 180°.**
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4. **Transfer of patients simplified**—no interfering structures, no separate tubestand.
5. **Easier movement of spot-film device** — you move approximately 180 pounds *less* longitudinally.
6. **Table pivots around central working area**—keeping screen-eye distance and radiologist's position practically constant.
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9. **Table lengthened to 7 feet.**
10. **Choice of three table heights.**

GENERAL ELECTRIC

Notes About People

Walter Hatch New Administrator at Kitchener-Waterloo Hospital

Walter Hatch has been appointed administrator of the Kitchener-Waterloo Hospital, Kitchener, Ont., and assumed his new duties in August. Mr. Hatch was on the staff of the Montreal General Hospital, for ten years, prior to his appointment as administrator of the Queen Elizabeth Hospital, Montreal, (formerly the Homoeopathic Hospital of Montreal). After 12 years as administrator at the latter hospital, he resigned in the spring to assume a position with a firm of investment dealers.

Mr. Hatch was a member of the Montreal Hospital Council, serving on the nursing committee of the Council, as well as being a former secretary-treasurer of the Montreal School for Nursing Aids.

Walter Hatch

A.S.L. Corner Accepts new Post at Lachine General Hospital

A. S. L. Corner, formerly administrator of the Nanaimo General Hospital, Nanaimo, B.C., has accepted the position of administrator at the Lachine General Hospital, Lachine, P.Q. Mr. Corner was born and educated in England but came to Canada in 1930, where he served on the staff of the Royal Victoria Hospital, Montreal, until his enlistment in the Royal Canadian Air Force, during World War II. Prior to his appointment at

A. S. L. Corner

Nanaimo, B.C., in October, 1951, Mr. Corner had been assistant administrator at St. Mary's Hospital, Montreal.

* * * *

Medical Superintendent Appointed at Sudbury-Algoma Sanatorium

Dr. C. J. Doherty, formerly medical superintendent of St. Mary's on the Lake Sanatorium, Haileybury, Ont., has been appointed medical superintendent of the Sudbury-Algoma Sanatorium, Sudbury Ont.

Born in Ireland, Dr. Doherty graduated in medicine from Dublin University and worked for several years as assistant chest physician for the city of Cardiff, Wales. In 1941, he enlisted in the armed services, serving until 1946 in the Far East where he was in charge of the British forces chest hospital in India. After World War II, he returned to Cardiff but came to Canada in 1948 to become staff physician at the St. Lawrence Sanatorium, Cornwall, Ont., prior to his appointment in Haileybury.

Dr. Douglas Mills Joins Staff of Hotel-Dieu of St. Joseph, Windsor, Ont.

Dr. Douglas Mills of Windsor, Ont., has joined the staff of the Hotel-Dieu of St. Joseph, Windsor, as pathologist. Dr. Mills received his medical degree from the University of Western Ontario, London, in 1948. Upon completion of his internship at the Victoria Hospital, London, he took a year of post-graduate study at the Regional Laboratory in that city. In 1950, he joined the staff of the pathology department at the Victoria Hospital and, in 1951, was appointed instructor on the staff of the University of Western Ontario Medical School.

* * * *

G. H. Shaw Appointed Personnel Officer of Royal Victoria Hospital, Montreal

G. H. Shaw has been appointed personnel officer of the Royal Victoria Hospital, Montreal, and assumed his new position at the beginning of September. Mr. Shaw is a graduate of McMaster University, Hamilton, Ont. For the past nine years, he has been

G. H. Shaw

assistant administrator of the Royal Edward Laurentian Hospital at Ste. Agathe des Monts, P.Q.

* * * *

Matron Appointed at Edgewood, B.C.

Mrs. Hazel Walsh, a native of New Zealand, has been appointed matron

(Continued on page 16)

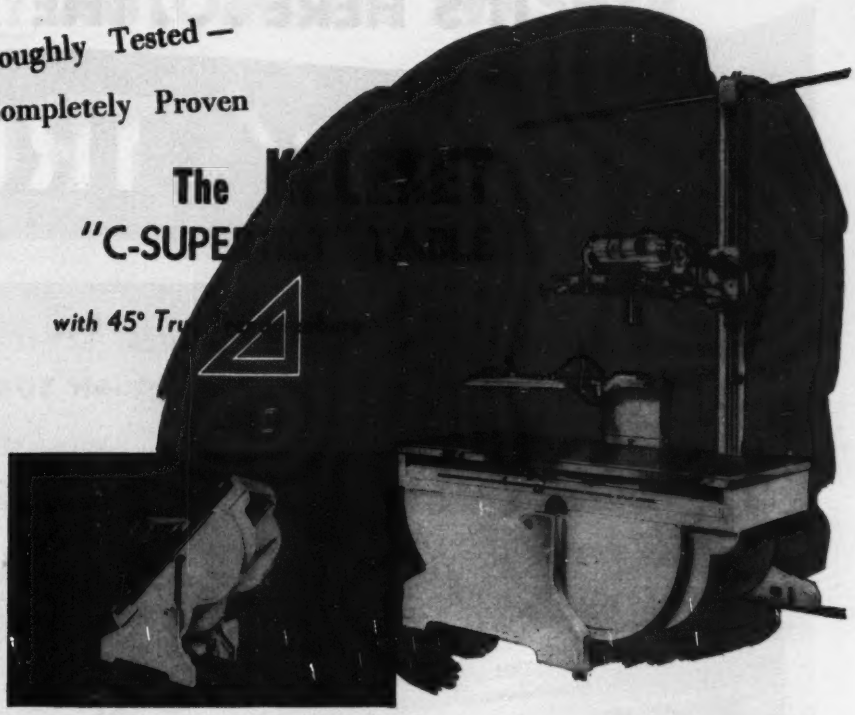
Thoroughly Tested —

Completely Proven

The

"C-SUPE

with 45° Tru



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- Many refinements and improvements since first introduced based on suggestions by radiologists actually using the table.
- Available in three models: Radiographic-Fluoroscopic, Radiographic Only, or Fluoroscopic Only.
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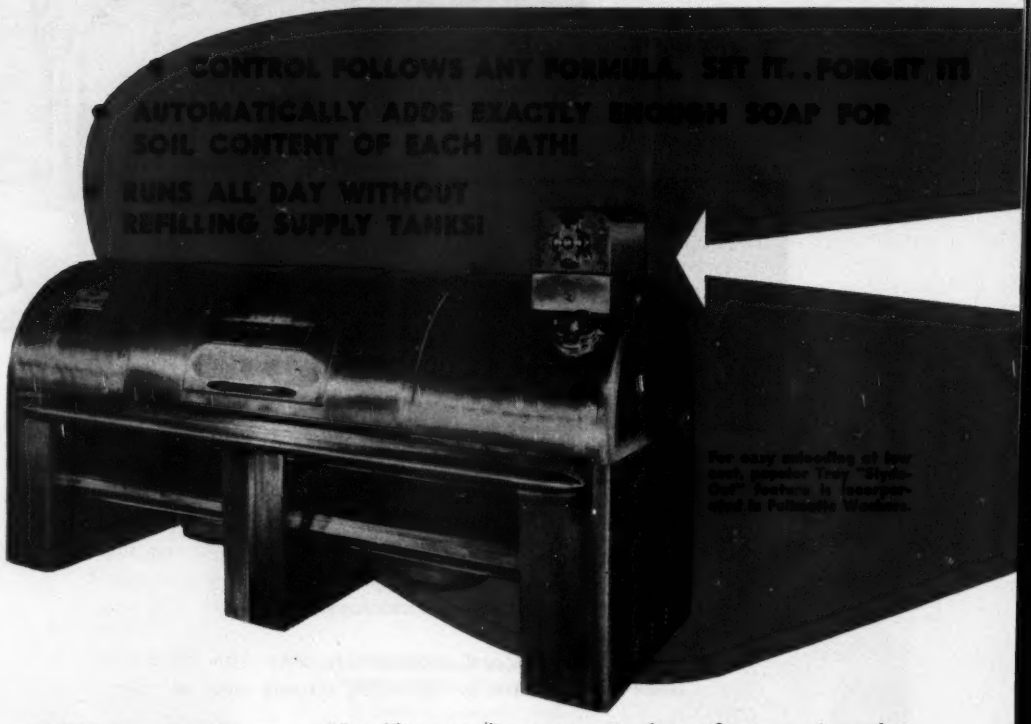
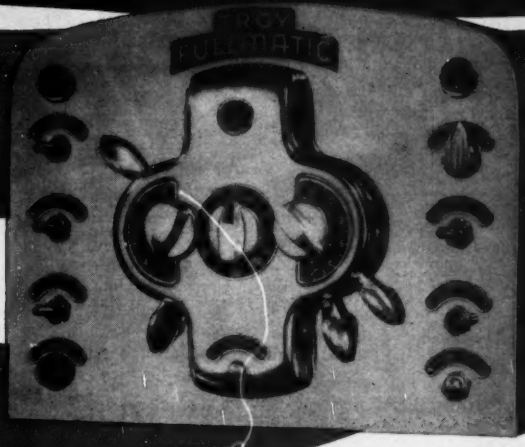


Now Troy proudly presents *the first truly automatic washer.* The Fullmatic Control follows any formula you select. Just set it and forget it. This control automatically regulates water temperature and fills cylinder to correct level for each washing operation . . . automatically injects exact amount of soap required for soil content of each load . . . adds measured amounts of other supplies when needed . . . regulates the number and length of suds and rinse operations . . . times each operation exactly, then drains machine . . . starts new operation . . . indicates washing progress by pilot lights . . . flashes 'finish' light and rings bell at close of washing cycle.

This new Troy Fullmatic is the result of 10 years of field research, engineering development and laboratory testing. In addition, selected laundries in different geographic locations have operated Troy Fullmatic Washers daily under actual

TRULY AUTOMATIC WASHER

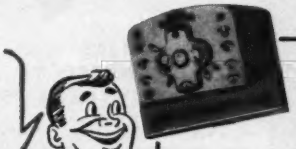
FULLMATIC *Washer*



"We have two Fullmatics . . . We are waiting anxiously for three more Fullmatics we have on order because we know we will be able to eliminate one man as soon as they arrive."
— Wilbur S. Kelley, Jr.
Vice President
Kelley Laundry and Dry Cleaners
San Diego, California

...tions. Charles N. Brock, owner of Getchell Laundry and ...Cleaning Company, St. Joseph, Missouri, says: *"We installed a Troy Fullmatic Washer at Thanksgiving time in 1950. Every day, I am more and more convinced that it is the best washer of its kind on the market, and one of the best investments we ever made."*

You can now buy an automatic washer with confidence. The new Troy Fullmatic is as flexible to use as your dial telephone and just as easy. Get all the facts . . . mail coupon below *today.*



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Notes About People

(Concluded from page 12)

of the Red Cross Outpost Hospital at Edgewood, B.C. Mrs. Walsh has been a resident of British Columbia for the past two years, where she specialized in private nursing. She succeeds Miss M. E. Mallory, who resigned to become matron of the Arrow Lakes General Hospital at Nakusp, B.C.

* * * *

Percy Ghent R.T.

Well-known as a writer in his own field, radiography, and as the author of historical sketches as well as studies of flora and fauna, Percy Ghent died on September 21 in his 65th year. Because of his varied interests, his constant zest and vivid personality, his death has brought a sense of personal loss—even to many who knew him only through his published works.

Born in England, Mr. Ghent came to Canada when very young and in 1910 joined the staff of the x-ray department (then in its infancy) at the Toronto General Hospital. Radiography was a comparatively new subject and radiology as a medical specialty was still to come. By continuous study and experimentation, the pioneer technician kept abreast of a field which developed with dramatic speed. When he retired in 1946, as chief radiological technician at the Toronto General, he had given 36 years of faithful service in his department, was the author of a brief biography of Roentgen and editor of *Canadian X-ray News Letter (C.I.L.)*. Mr. Ghent patiently and effectively taught student technicians and was ever willing to lend assistance to other staff members. He won for himself the genuine respect and abiding affection of the medical men whom he served, as well as his own associates. An eminent radiologist, when interviewed, declared "Percy *was* the x-ray department".

After his retirement, and despite ill health, Mr. Ghent energetically pursued not one but several hobbies. He collected literary and historical Canadiana, was keenly interested in gardening and was an active member of the Toronto Field Naturalists' Club. He ever and anon sought inside information about the fascinating things of nature by the use of x-ray. Many of his radiographs have appeared, with suitable text, in *Canadian X-ray News Letter*, including such diverse subjects as the chambered nautilis, bull frogs, dinosaur bones, and even an early oil painting of Mary Queen of Scots. For many years he had been a regular contributor to *The Telegram* (Toronto) and his thought-provoking essays, under the heading "Spotlight" gave pleasure to readers far and wide. He was also the author of two books "John Reade and His Friends" and "Literary and Historical Fragments of Canadian Interest".

* * * *

George W. Cragg M.D.

Dr. George W. Cragg, superintendent of the St. Lawrence Sanatorium, Cornwall, Ont., died on August 15th, at the age of 51, after a lengthly illness. A native of Greenbank, Ont., near Toronto, Dr. Cragg attended the Toronto Normal School. Later he enrolled in medicine at the University of Toronto, where he received his medical degree

(Concluded on page 72)

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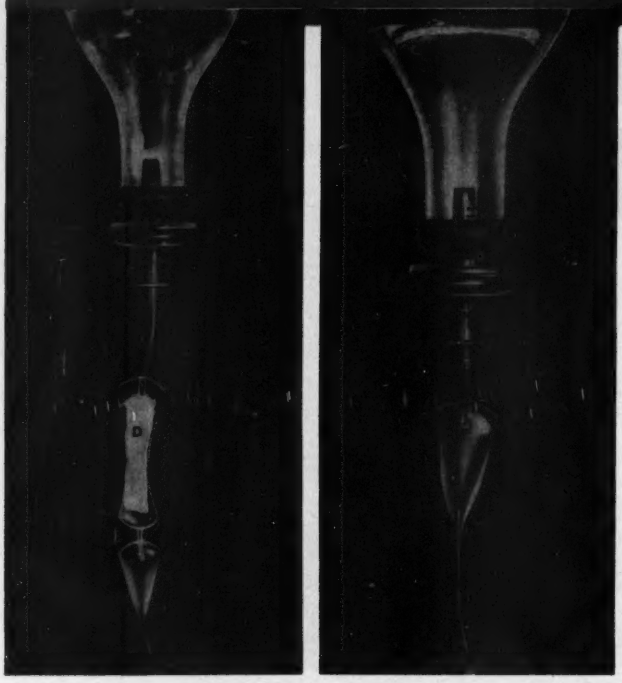

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*Sack, Theodore et al, The Preservation of Whole ACD Blood Collected, Stored, and Transfused in Plastic Equipment, Surg. Gyn. Obst. : 95, 113-119, 1952.
Walter, Carl, W., A New Technic for Collecting, Storage and Administration of Unadulterated Whole Blood. Surgical Forum.
Walter, Carl W., and Murphy, Wm. P. Jr., A Closed Gravity Technic for the preservation of Whole Blood in ACD Solution utilizing Plastic Equipment. Surg. Gyn. Obst.: 94, 687, 1952.

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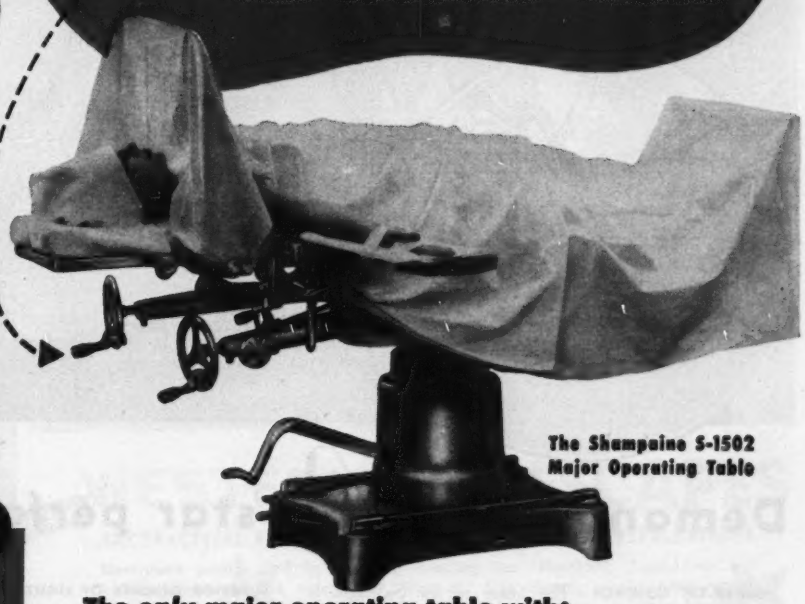

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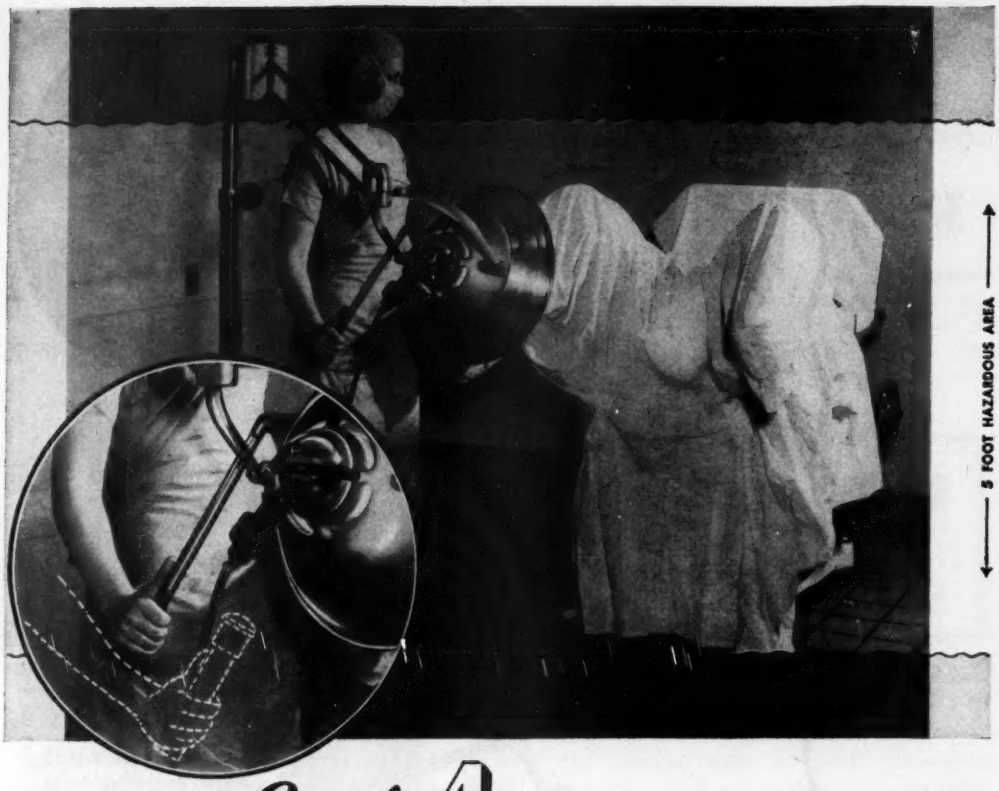

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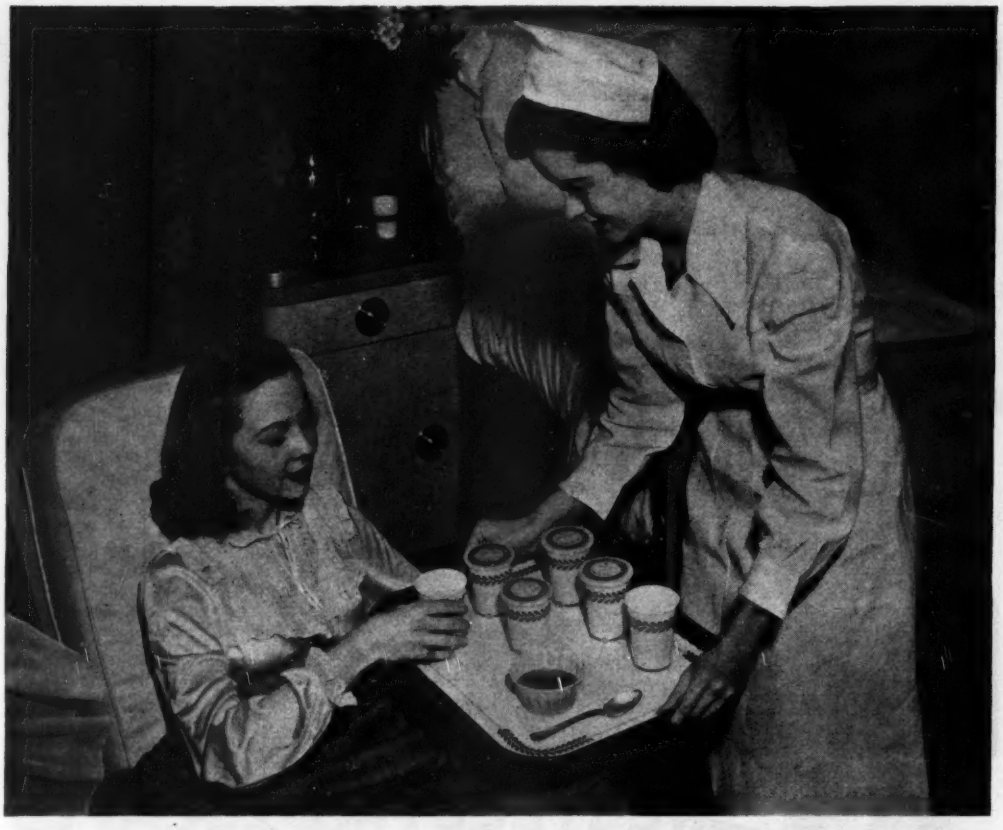

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A. L. Swanson, M.D., Editor

THE CANADIAN HOSPITAL

Toronto, October, 1952 Vol. 29 No. 10

Obiter Dicta

"Tuum Est" —

ON assuming new duties, presumably most of us would have somewhat similar hopes, ambitions and—fears. How shall we accomplish the task of carrying on and expanding a great work? How shall we compare with past incumbents?

These and dozens of other questions cross one's mind upon occupying the chair of well-known, highly-regarded, and experienced predecessors. They have set and maintained standards of the highest order, envisioned and helped to mould a purposeful, much-needed organization and, on departing, have left a gap that cannot be filled completely by anyone. For all of us are different, too, and cannot be poured into an identical mould.

What, then, has been left to the new incumbent? The bequest has actually been very large and we find ourselves far wealthier than most. An enthusiastic, trained staff, the respect of other hospital and medical organizations, the good-will of individual hospitals, and of voluntary and governmental organizations across the Dominion —these are but a few of our assets.

Tremendous progress has been made by the Canadian Hospital Council over the years; successive new fields of endeavour have been developed and still much remains to be done. Gradually Canada, hospital-wise, is coming to stand upon her own feet more and more completely. Without detracting or attempting to detract from the magnificent contributions made by our southern neighbour, Canadians are confident that they can progress via their own merits and resources. This is a natural feeling. It is right. It is good.

No one would suggest isolation from other countries, for hospital and other professional fields thrive on the exchange of knowledge and ideas. But we Canadians have evolved as a nation and wish to take our place in partnership with other leaders. So it is with hospitals. As such, it is a challenge to a new executive of the Canadian Hospital Council, while constituting still another asset.

Thus, sitting in the seat of the mighty, surveying the many resources, and contemplating the future of the Council, the motto of the University of British Columbia, cited above, comes to mind. The students of the University translate it freely to read, "It's up to you". Certainly in this great venture as executive secretary for our national hospital organization, and as editor of our official journal, these words should be my guide. But more than that—one individual cannot accomplish the task alone—we need the continued loyal and active support of all: Council directors and staff, member organizations, and others. *"Tuum Est"*.

Poor Publicity Affects Us All

EVERYONE in the professional field is particularly vulnerable to criticism by the public. Poor publicity affects us all and it takes only one unfortunate or careless act to heap trouble on the heads of many. In occupying positions of trust and respectability, we must be constantly jealous of this honour which may be stripped away at the slightest provocation. The resultant effects in terms of lost financial assistance for necessary work, lack of co-operation by private and government organizations, and loss of public confidence, can be crippling blows to hospital progress. Some physicians may stray far from the confines of the Hippocratic Oath; the odd clergyman may desecrate the cloth; there are bad apples in any barrel. What can we do to minimize or eliminate the effect of the occasional unscrupulous or indifferent member in the hospital field?

Recently, certain publicity, resulting from an investigation in Ontario, has been damaging to all hospitals. To combat this detriment, what are our broad lines of attack? First: by means of our public relations, we must convince the public that hospitals are basically sound, ethical organizations, directed and operated by competent individuals with a valuable service to render, and the strong desire to provide that service. Second: we must give thought to what action may be taken by provincial and/or, national associations to prevent such unhappy occurrences.

The first method rests mainly with the individual hospital or group of hospitals. Public utterances through press and radio may be initiated, portraying the essential part the hospital plays in the community. The hospital's role may be dramatized by emphasizing the life-saving work of the doctor and nurse in their daily duties. Direct and indirect reference may be made to the hospital's careful business methods, the frequent statements and auditing of accounts. These and other methods are well known to the live administrator and his board and require no further mention here. The second method, however, requires careful thought.

This brings to mind the question of qualifications for membership in hospital associations. Have any of our associations declined the application of any public hospital for membership? Have they the machinery to do so? If we exercise no discrimination in membership in our associations, has the public any assurance of quality of service from an economic as well as a medical point of view. If we exclude certain hospitals are we denying opportunity to the very organizations with the greatest need for guidance and help from a parent body? These are provocative thoughts and warrant careful consideration by our member associations.

It is not suggested that associations should have the power of enquiry. That involves many features which should only be undertaken with great caution. Legislative authority would be needed, but there is no reason why associations should not set some standards for admission to or expulsion from membership. Perhaps rather than exclude any hospital from the advantages of guidance and assistance, temporary, associate, probationary or other form of conditional membership might be employed. This would not deny a hospital educational benefits or the opportunity to have mature guidance from the association, yet would offer some regulatory and disciplinary force to the parent body.

It may be taken for granted that recognition as a public hospital by a provincial department of health is in itself an indication of compliance with all government requirements. Unfortunately, departments of health are so limited in staff that really adequate inspection is difficult. Then, too, were the provincial departments of health to augment their inspecting staff and offer more active and definite direction, would they tend to interfere with cherished hospital autonomy. In British Columbia, where this fear was rampant prior to hospital insurance, government activity has proved more helpful than overbearing. The British Columbia government has, thus far, taken the stand that hospitals must be properly operated and has offered considerable guidance in accounting methods, but has carefully refrained from actually attempting to operate the institution. (See article by George Masters, page 37).

Without presuming for a moment to judge the guilt or innocence of any party involved in an investigation by a commission, the purpose of the above comments is twofold: to encourage good public relations as a preventive to suspicion; to provoke serious thought at the provincial association level as to the merits of ethical business qualifications, as well as a hospital's qualifications for association membership.

"It takes everybody to run a hospital"

THE 54th Annual Convention of the American Hospital Association, (see page 56) was an outstanding success and a credit to competent organization. The meetings were of the highest calibre and were marked by the extensive use of advanced training aids. Plenty of microphones on the platform, good acoustics, tape recordings, dramatizations of problem situations, and careful timing combined to augment the efforts of distinguished speakers. Although the round table type of meeting, which was almost exclusively employed, did not delve as deeply into subjects as would formal presentation, it was a refreshing diversion from the expected.

Some administrators encourage their board members to enter into this milieu. Certainly it would seem difficult to find a finer method for orientating the thoughtful trustee in the complexity of hospitals and in the importance of their work. Many fine trustees in the local hospital field have very little knowledge of the provincial or national hospital situation and hospital meetings give scope for a broader understanding.

It may be that the directors would spot weakness in the home organization by comparison with other hospitals but this should be of assistance to the administrator in realizing improvements and should not work to his disadvantage. Likewise some issues concerning apparent weaknesses in the operation of the hospital, which are well nigh incomprehensible to the sound business mind, may be better understood when viewed in a broader light. The competent administrator who urges individual members of his board to accompany him to some of the major conventions establishes a closer liaison with his directors by virtue of increased understanding. As stressed at one AHA session, "It takes everybody to run a hospital".

Treating Communicable Diseases in the General Hospital

Eugenie Stuart, M.H.A.,
Assistant Professor,
Department of Hospital Administration,
University of Toronto,
Toronto, Ontario

A PERCEPTIBLE trend toward the treatment of acute communicable diseases in general hospitals reflects the progress which has been made over the past three decades in diagnosis, treatment, and control of such diseases, and is in keeping with changing concepts of hospitalization of other types of medical patients.

The care of patients with communicable diseases has posed a special problem in the field of medical care for many centuries. Biblical reference to leprosy (Leviticus 14:46) "All the days wherein the plague (leprosy) shall be in him he shall be defiled; he is unclean; he shall dwell alone; without the camp shall his habitation be," is one of the earliest suggested directives for segregation of those with communicable diseases. As a result of segregation many of the lazarettos of the middle ages still exist in Europe and Asia.

In the 16th and 17th centuries when there was little or no knowledge of modes of transmission of infectious disease, isolation hospitals for victims of small pox, typhus, and cholera, were erected in European countries. With the discoveries of Pasteur, Koch and Loeffler in the 19th century, a new vista was opened; but the belief that dissemination of these causative organisms through the air still existed. The opening of the Pasteur Hospital in Paris in 1900, which was constructed and equipped specifically for the care of patients with different communicable diseases on the same floor, proved conclusively that contact diseases were rarely transmitted through the air. On this continent the isolation hospital progressed from a wooden structure, the "pest-house", which usually housed patients with small-pox, to the more permanent isolation hospital for the treatment of scarlet fever, diphtheria and the other acute communicable diseases. These structures were primarily for segregation, with little thought being given to the medical and nursing care provided, so long as the patients were removed from the community. During the past two to three decades, progress in the control of acute communicable diseases through immunization, early diagnosis, isolation, improved nursing techniques, and public education, has made a phenomenal reduction in the morbidity rates of these diseases. This reduction in incidence, as well as recognition of the fact that the practice of strict medical asepsis is all that is needed to prevent the spread of these acute communicable diseases, is bringing about a change in our methods of hospitalization and directing our thoughts to the possibility of treating communicable diseases in general hospitals.

Difficulties Encountered

However, lack of public education, present day administrative procedures, and traditions built up in general hospitals, still to some extent discourage the acceptance of patients with communicable diseases. Necessary changes in hospital construction, or initial plans for construction of special units, additional special equipment for treatment, and training and keeping qualified personnel to care for these patients, are problems involving increased costs to the general hospital.

Eugenie Stuart

Comparably these costs to the community are considerably less than those annually accruing from the year to year maintenance of a separate isolation hospital. Although there are few isolation hospitals (the Dominion Bureau of Statistics lists only two in Ontario), their expenditures of public and private funds are out of proportion to the contributions which they make to the care of the sick and prevention of disease. Since these hospitals are not economical to operate, it is necessary for the general hospitals to consider admission of these patients—though this is not the legal responsibility of the voluntary hospital. Therefore the voluntary hospital, considering the care of this type of patient, might well ask the municipality to give special financial assistance for construction and a higher per diem payment. A hardship is imposed upon the patient and the isolation hospital, through financial arrangements laid down by certain provinces, *e.g.*, payment of the provincial grant per isolation day only. When the period of isolation is over the payment of this provincial grant ceases and costs to cover maintenance must be arranged on a new basis. In the event that the patient is unable to pay, the municipality in which the patient resides is responsible but the amount paid rarely if ever meets the costs of a special isolation hospital service.

When this unit is established in the general hospital, the facilities and staff are available at all times for the treatment and care of these patients, and the effectiveness of the isolation unit in the general hospital is enhanced by the medical skills in the various specialities which are available for consultation. In addition, in the large

From an address presented at the hospital sectional meeting of the American College of Surgeons, Toronto, May, 1952.

teaching hospitals, physicians, nurses, and other personnel, may have added educational opportunities through clinical resources. From the psychological standpoint, both of patient and family, it is a happier situation if the patient can be accommodated in the local institution.

Organization

In contemplating the organization of a unit for the care of patients with communicable diseases in the general hospital, the administrator must consider:

1. The seasonal incidence of these diseases and the flexibility of accommodation for economy of space as well as utilization of personnel.

2. The fundamental principles of the practice of medical asepsis and the structural features within a general hospital unit to facilitate good medical and nursing techniques for treatment of patients with communicable diseases.

3. The increased use of certain special services in the existing general hospital if a communicable disease unit is to be planned.

4. The development of a public education program to ensure understanding.

5. The development of an educational program for personnel.

Because of the seasonal incidence of these diseases it is difficult to estimate the number of beds needed for this type of patient. Dr. John B. Pastore, Executive Director of the Hospital Council of Greater New York, recommended, in 1949, in the "Master Plan for Hospitals and Related Facilities for New York City", 0.1 bed per thousand population, as a satisfactory ratio in New York City.[1] More important than the number of beds provided, is flexibility to enable conversion of these beds during periods when communicable disease incidence is low.

Location

In considering the location of the unit in the general hospital, it is generally accepted that these patients should be accommodated in that section of the hospital where medical patients are segregated. This unit should, as far as possible, be a terminal unit, in a part of the hospital where there is little traffic, with access to it by elevator or an entrance which can be supervised. In planning this unit single rooms are recommended, although one or more rooms may be planned to accommodate two patients with the same disease.

Measles (Rubella and Rubeola), mumps, chicken pox, diphtheria, infectious encephalitis, whooping cough, poliomyelitis, small pox, infectious hepatitis, pulmonary tuberculosis, influenza, pneumonia, and streptococcal infections, should be housed in separate rooms; but it is permissible to house some forms of meningitis, pneumonia, poliomyelitis, and tuberculosis, in cubicles. Although it is desirable to treat typhoid fever in a cubicle planned area, with observance of proper technique, typhoid fever may be treated in an open ward in the isolation unit.

Techniques

Each room in the isolation unit must have its own sink with a constant supply of hot and cold running water. The water supply should be controlled by specially-designed faucets, operated by either a foot or knee control or a hand tap which can be operated by the elbow. The usual techniques for hand washing requiring approximately three minutes should be practised.

Unless provision is made for the wearing of a clean gown by each person every time the room is entered, a gown rack for each patient should be provided. Gowning technique should be established and gowns should be changed daily. Where there are two beds in one room, two gown racks are necessary. Laundry bags for disposal of gowns and other contaminated linen should be conveniently located in service rooms.

The floors and walls should be of a material which is easily cleaned without damage or deterioration. Corridor walls should have adequate glass viewing areas so that visitors, under controlled conditions, may see patients without entering the room.

Beds, bedside tables, chairs and lights should be selected for ease and thoroughness of cleaning. Furniture should be at a minimum. In spite of these restrictions, the introduction of colour on floors and walls, and metal furniture finished in pastel colours, can make an attractive yet practical environment for these patients. Recognition of the fact that a higher incidence of communicable diseases occurs in children should influence the provision of special acoustical treatment in at least a few of the rooms of this unit. The care of this age group will also affect the space allocated and the facilities and equipment provided.

A patient coming to the general hospital with a communicable disease should be admitted directly to the bed which he will occupy and should not go through routine examination admission procedures which might contaminate other areas. In the large general hospital one room should be set aside in the admitting area for this type of patient, and the patient should be routed directly to this area without crossing lines of traffic where patients are being admitted to the general hospital area.

A service room between every two rooms is recommended to minimize corridor traffic. These service rooms must be planned to facilitate the sterilization and care of utensils, linen, and provide for disinfection and disposal of excreta.

If the food service is centralized, a kitchen with a sterilizer for disinfecting dishes before their return to the main kitchen must be included in this unit. If the food service is decentralized, sterilization of the patients' dishes must be carried out before return to the kitchen. This will necessitate clean and dirty kitchen sections.

All staff members should practice honest medical aseptic techniques in the care of every medical patient in the hospital. This practice, conscientiously applied in the light of complete knowledge of the modes of transmission of the acute communicable diseases, is the foundation for care, without danger of cross-infection, of this special type of medical patient in the general hospital.

Personnel

Conscientious, trained personnel must be responsible for the care of the patients with communicable diseases in this unit, as well as preventing any contact by patients or personnel outside of this unit. All who work with this unit must strive for 100 per cent adherence to the principles of medical asepsis. The supervisor of the unit should have special training in bacteriology and should know the course of all communicable diseases, sources, modes of infection, immunization, incubation and quarantine periods, and complications. She must accept the full responsibility for teaching proper techniques to all personnel working in the unit and for ensuring adherence to all special procedures practised in the unit.

A manual of accepted routines and

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1. Emerson Haven, M.D., "Administrative Medicine"

Dedicated to the Memory of Fishermen

Lunenburg, N.S.

EARLY in July, the new Fishermen's Memorial Hospital was officially opened in Lunenburg, N.S., signifying the successful conclusion of several years of community effort and planning. In 1945, with the nearest hospital twelve miles away, the citizens of Lunenburg were becoming more and more aware of the necessity of having a hospital in their own town. That year, they raised over $100,000 in a campaign for funds. In 1948, construction of the hospital began. In 1951, another successful fund-raising campaign was carried out and a trust fund, which had been accumulating for the purpose of erecting a memorial to the men of the fishing fleet who had lost their lives at sea, was given to the hospital. A cornerstone was dedicated, a plaque erected, and the name of the hospital became, officially, the Fishermen's Memorial Hospital. The hospital is operated by the Lunenburg Hospital Society.

Of reinforced concrete construction, the building has two storeys and is "T"-shaped. The main floor contains six private rooms, five semi-private, and one three-bed room, as well as two wards, one with eight beds and the other with four. With the two isolation rooms containing two beds each in the basement, there is a total bed capacity of 35. The nursery has 11 cubicles. On the main floor of the building are, also, the x-ray room, an emergency treatment room, two operating rooms, a sterilizing section, delivery room, doctors' lounge, laboratory, diet kitchen, linen room, utility and supply closets, waiting room, and nurses' station.

The basement contains a laundry, sewing room, linen room, kitchen, nurses' dining room, board room, maids' dining room, and maids' quarters for six. There is a three-compartment cold storage, a vegetable and grocery room, and a storeroom for drugs and other surgical and medical supplies.

The second storey of the hospital has not yet been completed. When finished, it will provide nurses' quarters or space for additional patient beds.

The total cost of the new hospital was approximately $342,000. About $77,000 were spent in furnishings, although various local clubs, and labour unions helped to furnish several rooms. The architect was C. St. J. Wilson of Halifax, N.S.

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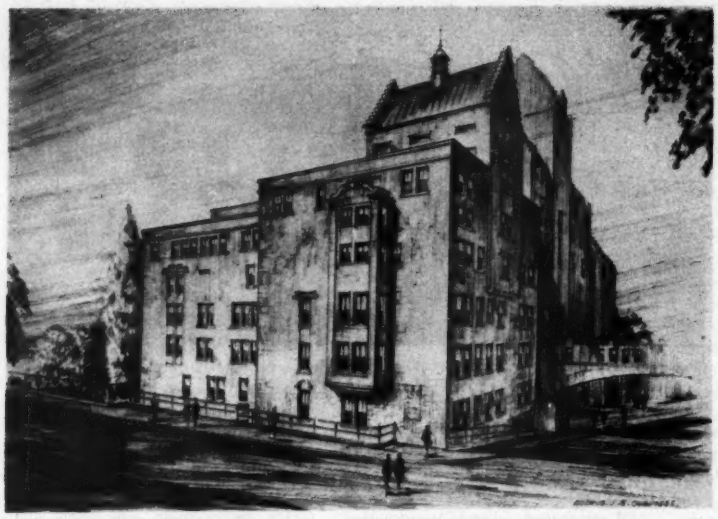
procedures should be established by a joint committee representing the administrator, medical staff, and nursing staff of this unit, and the local officer of health of the district. This manual will form the basis for instruction of personnel and should be available for reference to all who work in the unit. It should include housekeeping procedures for the non-professional personnel to avoid the possibility of spreading communicable diseases. To prevent duplication in the preparation of this manual, as well as to standardize these procedures, it is suggested that this work might be considered at the provincial or federal level, with respect to principles and routine techniques, and these may be adapted to fit the local situation. However, with adequate physical facilities these techniques are simply those which should be practised continually in the care of all medical patients whether they be in this special unit or not. Personnel assigned to this unit should be routinely tested and immunized against the acute communicable diseases.

The care of these patients is divided between medical, nursing, dietary, and housekeeping staff. All personnel must adhere to the standards established for the care of patients with communicable disease. Physicians, nurses, and housekeeping staff, are in close contact with these patients and each person must follow the procedures of washing, gowning and wearing of masks, while caring for patients. "A chain is only as strong as its weakest link", and one weak link in this unit may have disastrous effects. The personnel of the dietary department will not have direct contact with patients but facilities and routines for sterilization of contaminated dishes and left-over food must be planned and followed.

Medical Services

The New York State Department of Health has recommended that "every hospital designate one physician with a knowledge of communicable diseases (1) to investigate all unexplained infections occurring in patients and personnel; and (2) to review the isolation technique of the institution from time to time and recommend necessary changes". This physician would be the chief of the communicable disease service in the medical staff organization. He would be available for consultation, and conferences, and would

(Concluded on page 114)



Montreal Neurological Institute

New Wing to Contain Decontamination Unit

A NEW north wing is to be added to the Montreal Neurological Institute pictured above, which will double the floor space of this world famous institute. In the architect's sketch, the new McConnell wing is to the left and the present building to the right. The bridge, at the right, provides access from the institute to the Royal Victoria Hospital across the street. The estimated cost of the new unit is $2,300,000.

The institute, which is a complete hospital, on the one hand, and a scientific establishment, on the other, has grown tremendously in stature since 1934, when it was constructed at a cost of $500,000, contributed in equal amounts by the Rockefeller Foundation of New York and by citizens of Montreal. The foundation also endowed its scientific research to the extent of $1,000,000. Increasing support, largely from national and international sources, has made it possible to extend the research activities which are set up independently of hospital operation, each with its own revenues.

The increasing number of patients has forced expansion from 47 to 100 beds in the present building, and has necessitated the use of a temporary military annex, built by the federal government and used until recently. With the building of the new wing there will be 130 beds available, as well as greatly expanded facilities for vitally important research.

The exterior design of the new wing is Scottish baronial, to harmonize with the existing building, with walls of Montreal limestone quarried at Pont Viau, P.Q. It will consist of a basement and seven floors, with provision for an additional floor. The floor levels in the existing building will be maintained in the new wing and there will be space for two additional elevators.

Disaster Casualty Ward

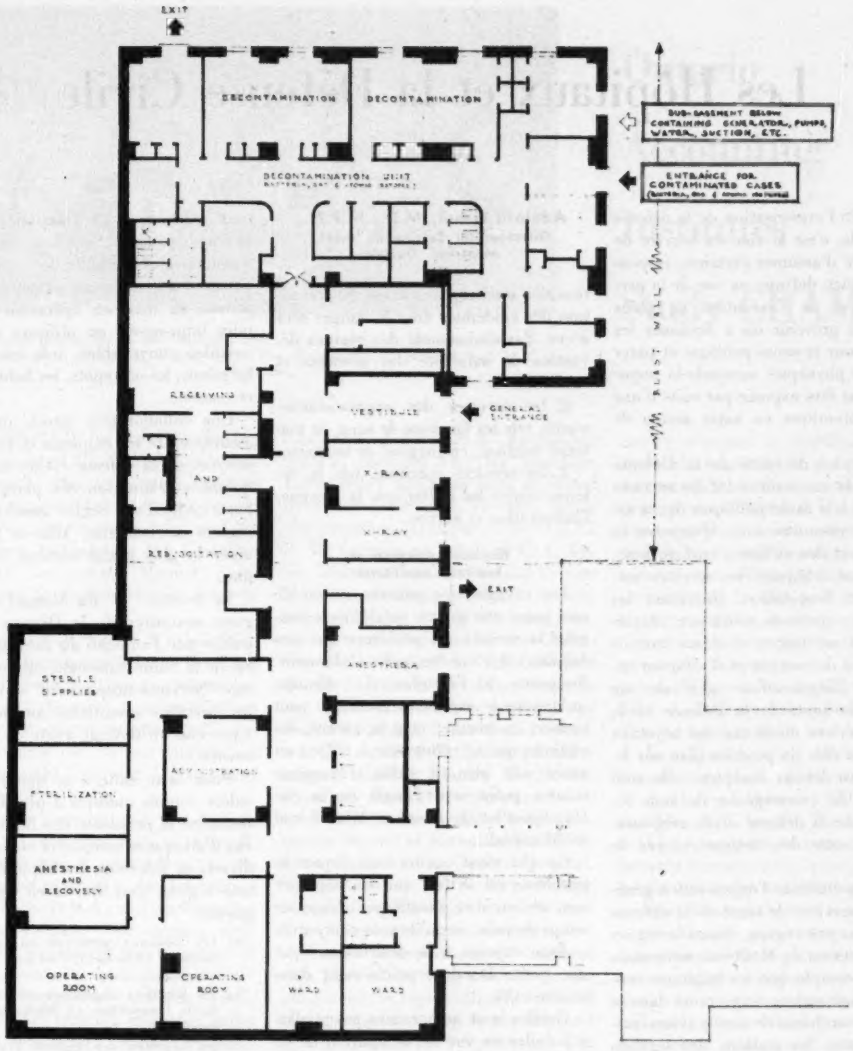
A disaster casualty ward, which would become available if Montreal were subjected to atomic bombing, has been included in the re-organization and expansion plans. This ward, the first of its kind in a civilian hospital in Canada, has been made possible through careful planning of the basement of the new wing, a large part of which will be hewn out of solid rock. A special blast wall will protect it on the exposed side.

The basement, which will be used in peace-time for a variety of purposes, is planned in such a way that it can be used for the decontamination of cases involving bacteria, gas or atomic isotopes. It has facilities for resuscitation, anaesthesia, and x-ray, as well as space for wards and operating rooms.

This section has been laid out with the advice of medical experts from Canada's Chalk River atomic energy project. It is designed so that it can be set up as a self-contained area, in case of damage to the upper floors. The services, such as water, steam, vacuum, and heating, are on separate systems.

Patient Accommodation

Owing to the type of nursing necessary for patients at the institute, special wards have been planned which are quite different from those found in a general hospital. The new public and semi-public wards have 8 beds. The nurses' stations are so arranged that there is visual observation of all patients at all times. In connection with the size of the wards, it has been found that the recovery of patients is quicker when they share the com-



Alternative Basement Plan for Disaster Casualty Ward

panionship of others.

A small recovery ward has been planned close to each large ward so that post-operative treatment and medical and nursing care can be carried out under the optimum conditions required immediately after operation. A new operating room has been provided, with a spectator gallery for students. Scrub-up rooms, robing, and anaesthesia rooms are also in this section.

Additional Research

One of the outstanding contributions of the institute is the amount of research which is carried out in a variety of related subjects designed to further the progress of neurology and neurosurgery and provide, as well, basic knowledge which may prove helpful in other medical sciences and research.

In the new wing and in the existing building it is planned to provide additional lecture and conference rooms, an x-ray department, and laboratories, as well as much-needed staff rooms, sterilizing rooms, dressing and treatment rooms, bathrooms, and storage. A special isotope laboratory is being organized as part of the x-ray department. This will be used for the application of radio-active isotopes in diagnosis and treatment.

A feature of the new wing, which will be much appreciated by patients,

(Concluded on page 108)

Les Hôpitaux et la Défense Civile

Adélard Groul, M.D., M.P.H.,
Directeur du Service de santé, Montréal, Québec

DANS l'organisation de la défense civile, c'est le rôle du service de santé d'assumer certaines responsabilités bien définies en vue de la préparation et de l'exécution de plans destinés à prévenir ou à diminuer les risques pour la santé publique et parer aux aléas physiques auxquels la population peut être exposée par suite d'une attaque atomique ou autre action de l'ennemi.

Le Service de santé de la Défense Civile, tout en maintenant les services essentiels à la santé publique, devra assurer les premiers soins d'urgence et le transport des victimes, voir au fonctionnement adéquat des services médicaux et hospitaliers, distribuer les approvisionnements médicaux, chirurgicaux et sanitaires, et même fournir un service de morgue et d'inhumation.

Dans l'organisation générale du Service de santé de la Défense civile et des services médicaux, les hôpitaux jouent un rôle de premier plan sur lequel nous devons compter. Ils sont le point de convergence de tous les services de la défense civile responsables des soins des victimes en cas de désastre.

Si nous étudions l'organisation générale des services de santé de la défense civile dans une région, disons la région métropolitaine de Montréal, nous nous rendons compte que les hôpitaux constituent une section importante dans la division ou branche des services médicaux, avec les sections des services d'ambulances, des postes mobiles de premiers secours, de l'évacuation des victimes, des services de pratique médicale et de nursing.

En plus de cette branche des services médicaux, qui comprend la section des hôpitaux comme nous venons de le voir, l'organisation des services sanitaires de la défense civile pour la région métropolitaine en a aussi trois autres:

1. les services d'hygiène publique qui prévoient la collecte et la compilation des statistiques vitales, la prévention des épidémies dont le danger sera accru, l'assainissement des régions dévastées, la salubrité des aliments et caetera;

2. les services des approvisionnements, tels les banques de sang, la matériel médical, chirurgical et sanitaire;

3. les services spéciaux, tels la défense contre les radiations, la morgue, l'inhumation et autres.

Hôpitaux existants et hôpitaux auxiliaires

Les ravages que peuvent causer de nos jours une guerre totale nous donnent la mesure du problème que nos hôpitaux doivent être prêts à affronter. Songeons à l'étendue du désastre qu'une seule explosion atomique peut causer, au nomber et à la variété des victimes qui en résulteraient. Pour en avoir une idée, il suffit d'imaginer comme point zéro l'angle de la rue Hutchison et de l'avenue Mont-Royal en Montréal.

Ce qui vient encore compliquer le problème est le fait que les hôpitaux sont en nombre insuffisant même en temps de paix, et qu'ils sont concentrés —donc exposés à la destruction—sur une petite étendue, précisément dans la zone-cible.

Quelles sont les mesures essentielles à prendre en vue de la solution de ce problème?

Il importe de faire d'abord un relevé, un inventaire des facilités hospitalières déjà existantes dans la zone-cible et la zone d'aide mutuelle. A ce sujet Ottawa, pour faciliter la tâche et pour fins d'uniformité, nous a fourni un plan comprenant une série de formules qui devront être remplies par chaque hôpital. Montréal a déjà fait, par questionnaire, une étude des disponibilités et des besoins des hôpitaux métropolitains, en vue de la situation qui pourrait nous être créée par un désastre.

L'idée maîtresse est de procéder à une organization adéquate des hôpitaux existants pour l'emploi de leurs facilités jusqu'à l'extrême limite. Il s'agit en plus d'établir des plans d'expansion des hôpitaux existants et de prévoir la mise en opération d'hôpitaux improvisés, en utilisant des immeubles convenables, tels les écoles, les hôtels, les entrepôts, les habitations, et caetera.

Une collaboration étroite doit être assurée entre les hôpitaux et les autres services de la défense civile, de même qu'une coordination des plans de défense civile d'une région avec ceux des régions avoisinantes, afin de pouvoir aider le plus grand nombre de victimes.

La Section "E" du *Manuel des services sanitaires de la Défense Civile*, publie par l'autorité du ministre fédéral de la Santé nationale, est consacrée aux "Services hospitaliers" et contient les directives essentielles aux hôpitaux (que chacun devrait avoir en sa possession).

Pour faire suite à ce que j'ai considéré comme mesures à prendre pour résoudre le problème des hôpitaux en cas d'attaque atomique, et en vertu des directives fédérales, les hôpitaux, dans une région, sont divisés en trois catégories:

(a) Les hôpitaux généraux ou spécialisés existants localement, c'est-à-dire dans la zone-cible;

(b) les hôpitaux improvisés ou immeubles divers transformés en hôpitaux dans la zone-cible;

(c) les hôpitaux des régions avoisinantes, avec lesquels l'organisation locale devra se tenir en relation.

L'organisation des services hospitaliers dans les hôpitaux généraux ou spécialisés existants et dans les hôpitaux improvisés est la responsabilité du comité local ou métropolitain (c'est le cas pour Montréal, zone-cible), section du service de santé de la Défense Civile avec, je le répète, la collaboration des hôpitaux eux-mêmes qui ont aussi leur propres responsabilités.

Quant aux hôpitaux régionaux, c'est-à-dire localisés dans les régions avoisinantes, leur organisation dans la défense civile dépend d'un comité provincial qui devra assurer la coordination

Une adresse présenté à une séance de la section de Québec de l'American College of Surgeons février, 1952, au Château Frontenac, Québec, Canada.

Among instructors at the institutes were, left to right: S. W. Martin, O. G. Smith, G. J. McQueen, Murray Ross, Roy Erdman, B. R. Blishen, and E. C. Robinson.

Ontario Accounting Institutes Study CHAM

SPONSORED by the Ontario Department of Health and the Ontario Hospital Association, two institutes for the purpose of studying the revised statistical reporting schedules and the procedures outlined in the Canadian Hospital Accounting Manual were conducted in Ontario during September.

Each Institute was of 3 days' duration, the first being held at the King Edward Hotel in Toronto, September 10-12, and the second at the Chateau Laurier, Ottawa, September 25-27. Total enrolment for the two courses was approximately 235, with 135 hospitals represented.

Program planning and preparation, under the chairmanship of Eric R. Willcocks, was a joint effort of the Department of Health, the Accounting section of the O.H.A., and the Canadian Hospital Council. The courses were financed (including the expenses of one representative from each hospital) by the Department utilizing funds available for training purposes under the National Health Grants Program.

George J. McQueen of Hamilton, Chairman of the O.H.A. Accounting Section, presided over the meetings. Introductory addresses were presented by Arthur J. Swanson, Toronto, Executive Secretary-Treasurer of the O.H.A., R. W. Erdman on behalf of C. J. Telfer, Director of the Public and Private Hospitals Division, Ontario Department of Health, Dr. W. Douglas Piercey, Ottawa, Chairman of the O.H.A. Executive Committee, and Herbert Marshall, Ottawa, Dominion Statistician. Study material was presented by Ocean G. Smith, Consulting Accountant, O.H.A.; Roy W. Erdman, Department of Health; Stanley W. Martin, Associate Executive Secretary-Treasurer, O.H.A.; Bernard R. Blishen, Dominion Bureau of Statistics; E. C. Robinson, St. Catharines General Hospital, St. Catharines, W. E. Cox, Guelph General Hospital, Guelph, and Murray Ross, Canadian Hospital Council.

Formal presentations of material took place at morning sessions. In the afternoons the registrants were divided into groups according to the size and type of hospital each represented. The smaller groups examined in detail the entries required in handling transactions of various types along the lines recommended in the manual. This procedure was facilitated by having at hand sample journals, general ledger, trial balance, and reporting schedules with amounts filled in, through which entries could be followed from origin to statement.

Section leaders in charge of the group discussions were: R. B. Ferguson, Weston; W. A. Murphy, Oakville; A. T. Story, Owen Sound; Sister Teresa Agatha, Sault Ste. Marie; W. E. Cox, Guelph; E. C. Robinson, St. Catharines; M. B. Wallace, Toronto; W. A. Holland, Oshawa; William Hunt and Miss G. I. Beatty, Toronto.

Discussion periods were lively and brought forward many questions which helped materially in obtaining a clearer understanding of the new requirements.

Attendance, punctuality and sustained interest throughout the institutes were sources of satisfaction to the sponsors, who are to be congratulated on a task well planned and executed in a field where educational programs of this nature are very timely.—M.W.R.

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et la relation avec le comité local municipal ou métropolitain.

Les hôpitaux de chaque catégorie ont des responsabilités propres, en regard d'un état d'urgence.

Responsabilités des hôpitaux existants

Chaque hôpital général ou spécialisé existant devra, dans une zone-cible, appliquer les plans généraux d'organisation préparés en vue d'un état d'urgence, et établis par la section et le comité des hôpitaux de la défense civile.

Il devra former un comité de défense civile et nommer un médecin, chef de la défense civile du personnel hospitalier; il est préférable que ce médecin soit exempte d'administrer des soins aux malades, parce que ses nouvelles obligations exigeront tout son temps.

En troisième lieu, il devra aussi élaborer des plans d'urgence qui doivent reposer sur certaines données essentielles fixées par le comité national et auxquelles je vous réfère; il serait trop long de les énumérer ici; il appartient à chaque administrateur d'hôpital et au chef de la défense civile nommé de les étudier et de les appliquer dans son établissement.

Chaque hôpital devra donner, en temps d'urgence, des soins hospitaliers adéquats aux malades et aux victimes et admettre ceux dont l'état le nécessitera. Pour cela, il faut tenir compte du nombre actuel des lits et de la

capacité d'expansion.

Devant la menace d'une attaque imminente, l'hôpital devra évacuer tous les malades et les blessés dont l'état le permet sans danger, vers des endroits prévus, soit leur foyer, soit les transférer dans des centres de convalescence, des hôpitaux régionaux, ou ailleurs; et réserver les facilités hospitalières uniquement aux soins des grands blessés et des personnes gravement malades; ne pas répéter l'erreur qui semble s'être commise en Angleterre durant la dernière guerre et, à ce sujet, Richard M. Titmuss, dans son livre *Problems of Social Policy*, écrit, au chapitre 11, "Hospitals and Transition": "Surely never before, has a nation inflicted such untold suffering on itself as a precaution against potential suffering. And was it all necessary? . . . War or no war, there could not fail to be civilian sick . . . Why should it have been considered less disastrous for anyone to die untreated of cancer, appendicitis or pneumonia than as the result of a bomb?"

Chaque hôpital aura son programme d'expansion, conforme au plan général élaboré par le comité des hôpitaux, qui consistera à accroître le nombre de lits et leur facilités à la limite extrême allant jusqu'à la proportion de 75 pour cent de leur capacité normale; avec aménagement de lits additionnels et l'emploi maximum de l'espace disponible; augmenter le nombre des salles d'opération; augmenter (de 70 pour cent) les stocks normaux des fournitures médicales, tels les médicaments, les compresses, les attelles, et caetera, et établir un service auxiliaire de morgue.

Il faudra, dans chaque hôpital, pourvoir à une réorganisation et à une réorientation des services hospitaliers, en prévision de besoins nouveaux, par l'accroissement du personnel hospitalier non professionnel, du personnel de bureau ou autre et du personnel professionnel, médecins, chirurgiens et infirmières, et par une réparation du personnel médical et de ses fonctions en cas de désastre; on devra établir des équipes ou unités de médecins et de chirurgiens de réserves affiliées aux hôpitaux; chaque unité sera constituée par des médecins et chirurgiens non éligibles pour le service militaire; ces équipes retourneront à l'état de réserve aussitôt que l'état d'urgence aura cessé; chaque membre sera commissionné, c'est-à-dire rétribué dès le moment où il se rapportera à son poste en période d'urgence.

Il faudra déterminer le nombre des victimes qu'un hôpital peut accommoder; réorganiser le personnel infirmier et constituer des équipes par l'intermédiaire des associations d'infirmières existantes.

Le service de l'alimentation de l'hôpital devra aussi être organisé pour qu'il soit en mesure de nourrir promptement et à l'improviste un grand nombre de victimes, le personnel de l'hôpital et les voluntaires des bureaux et des autres services essentiels: service du génie sanitaire et de l'entretien, service d'utilité publique: eau, toilettes, destruction des déchets, électricité, chauffage, protection contre l'incendie, et caetera.

Voilà, en résumé, pour ce qui concerne l'hôpital existant en se rappelant qu'en temps d'urgence, il faut assurer le fonctionnement efficace de l'hôpital et intégrer ce dernier dans le plan d'ensemble de la défense civile.

Responsabilités des hôpitaux d'urgence

C'est aussi la responsabilité des hôpitaux avec la coopération du comité des hôpitaux de dresser à l'avance des plans pour utiliser d'autres immeubles, les choisir, les convertir en hôpital d'urgence et en assurer le fonctionnement.

Dans le choix des immeubles, il faut déterminer s'ils conviennent à y établir des hôpitaux d'urgence et se rappeler les exigences du service des soins infirmiers. Ces hôpitaux d'urgence peuvent remplir les fonctions des "Casualty Stations" aux Etats-Unis.

Ces hôpitaux improvisés assumeront le traitement, complet et définitif, chaque fois que la chose sera possible, de toutes les victimes qui ne nécessiteront pas des soins chirurgicaux spécialisés immédiatement. La majorité des cas de brûleurs graves, les victimes des radiations, les cas de fractures ordinaires et de lacérations étendues mais superficielles constituent donc les principales responsabilités des hôpitaux d'urgence.

Le Manuel des services sanitaires (section "E"—chapitre 2), publié par le ministère de la Santé nationale à Ottawa, comprend un plan des préparatifs auquel il est bon de référer dans l'organisation des hôpitaux improvisés.

Dans le choix des immeubles pouvant loger des hôpitaux d'urgence, en règle générale, ceux qui conviennent le mieux sont les écoles, et les hôtels. Ces derniers offrant des avantages, tels: chambres à coucher déjà aménagées, une grande cuisine, une buanderie, et caetera.

Les hôpitaux régionaux de réserve

Les hôpitaux régionaux, situés dans les régions avoisinantes, zones de réception, dirigés d'après le plan général de la défense civile par un comité provincial, avec lequel travaillera le "Comité métropolitain des hôpitaux", recevront les malades et les blessés référés par les hôpitaux improvisés et les stations mobiles de premiers secours. Ils constitueront une réserve régional dans les petites localités, pour recueillir les malades évacués des hôpitaux situés dans une zone d'une attaque imminente.

Ce sera la responsabilité des directeurs locaux de la défense civile de consulter les autorités provinciales de la défense civile au sujet de l'utilisation des hôpitaux régionaux pour y transporter les malades de la région dévastée. Il s'agira donc (important à noter), d'une aide mutuelle relevant des autorités provinciales et locales.

Comité des hôpitaux et ses responsabilités

Les hôpitaux existants et les hôpitaux improvisés, comme je le disais dans mon entrée en matière, constituent l'une des sections principales dans l'organisation du Service de santé et de soins médicaux de la Défense Civile d'une région. Il est important que le directeur de ces services soit secondé et aidé par un directeur adjoint du sous-service des services médicaux et par un "Comité des hôpitaux", dont la mission sera de contribuer à l'organisation des hôpitaux et définir leurs responsabilités, préparer un plan d'ensemble uniforme, et caetera.

A Montréal, nous avons récemment jeté les bases d'un tel comité du service hospitalier dans l'organisation métropolitaine de la défense civile; ce comité comprendra des représentants du Conseil des hôpitaux de Montréal, M. J.-H. Roy, qui a été élu son président, et les docteurs J.-R. Boutin et J.-G. Turner, les docteurs Origène Dufresne et E.-F. Crutchlow, représentant respectivement la Société médicale de Montréal et la Montreal Medico-Chirurgical Society, le docteur Jules Mercier, surintendent médical du Queen Mary Veterans' Hospital, le docteur C.-S. Thomson, chef de la Défense Civile à l'Hôpital Royal Victoria et les

(suite en la page 80)

Hospital Insurance in British Columbia

George Masters,
Administrator,
Royal Jubilee Hospital,
Victoria, B.C.

UNIVERSAL hospital insurance for all of the citizens of British Columbia, by legislation, has been a lusty baby which grew into full manhood within the short period of three years; and everyone in the province had his or her personal views on how to rear the child. The insurance scheme has been of great value to hospitals and to all families beset by sickness; and the medical profession, too, has a full realization of its value. Although hospital insurance is here to stay, there will always be those persons who will seek amendments to the regulations to fit their particular circumstances. The early success of this revolutionary scheme in this part of Canada has been entirely due to the generous and understanding attitude of the government officials towards the hospitals.

Twenty years experience with Blue Cross has proved the value of prepaid hospital care; but a controversy still rages with regard to the need and ultimate results of *compulsory* prepayment for hospital care.

British Columbia has had a compulsory plan of hospital insurance for three and a half years and, although disputes with regard to the administration and minor policy regulations still exist, there is almost no vestige of discontent on the part of the citizens in accepting the prepayment of hospital care. The demand was there and, basically, the demand has been met.

Development of the Plan

During the period, 1946 to 1951, the cost of hospital care has doubled in both the United States and Canada and the provincial governments have been caught up in the cyclone of spiralling costs by awarding increasing grants to hospitals each year. To assist hospitals in meeting their operating deficits for the years 1947 and 1948, the government of the province of British Columbia made very substantial grants-in-aid, in addition to the regular statutory grants. While providing this assistance, the government could find no sign of relief, in the foreseeable future, from the incessant demands of the hospitals for further aid unless province-wide hospital insurance coverage could be provided. At the same time, the hospitals were beset by labour problems and increased commodity prices, together with an expanding economy which increased the demand for hospital services.

In contradiction to the spiral of inflation, it was found that the public was quite unable or unwilling to pay for the growing cost of hospital care and, therefore, "bad debts" increased by hundreds of thousands of dollars in the 1947-1948 period.

An act to provide for the payment of compulsory hospital insurance by all the citizens of British Columbia was presented to the legislature at the spring session of 1948 by the Honourable George S. Pearson, then Minister of Health and Welfare. Mr. Pearson had long been interested in hospitals and felt that it would be better to take action on this matter rather than wait for the results of a full study which might delay the program and focus attention upon difficulties which would appear insurmountable. The Minister was then, and still is, in his retirement, an idealist and at all times was a thoroughly honest servant of the public. He enjoyed the confidence and support of his party and, by the same token, that measure of support which enabled him to sell his idea of hospital insurance to the legislature.

George Masters

The Hospital Insurance Act became effective early in 1948 and a public health officer, Dr. J. M. Hershey, was appointed as Commissioner of Hospital Insurance with instructions to have the plan in full running order by January 1st, 1949.

Dr. Hershey selected a group of young men of ability from several government departments and they went to work in all earnestness to surmount a Herculean task. With no chart to guide them, they succeeded in reaching the primary objective of having the plan in operation by the desired date and for this effort they deserve high commendation. The amount of spade work necessary was incalculable. Everyone in the province had to be registered, plans formalized for the administration of hospital payments, and branch offices opened and staffed in each community. It is a wonder that the central group ever slept at all during the formative period.

Philosophy of Insurance

British Columbia Hospital Insurance Service was conceived as a scheme which would be wider in scope than private insurance schemes and geared to keep pace with the expanding economy of the province. Because of geographical difficulties in the area and the large population of itinerant workers in the major industries, it had been found that Blue Cross was unable to reach adequately the people who needed protection; and because of the restricted benefits of existing insurance plans, the public was not protected against catastrophic hospital bills. To be sure, unrestricted benefits for acute hospital care may not be

actuarily sound but the proportion of large hospital accounts was not considered to be great enough to place undue financial strain on the economy of the plan. More important, such a program certainly meets a public need. At any rate, patients were previously quite unable to pay the larger bills and such accounts would result in a public charge in most cases. Moreover, the hospitals would need further subsidy if the accounts were not to be paid by the insurance scheme.

It was further expected that a system of prepayment for hospital care would elevate the hospitals from the doldrums of the depression and war years and would permit them to lift themselves by their bootstraps, and begin to modernize their depleted plants. In this connection it was also felt that, because operating revenue was assured, the hospitals would not hesitate to recruit financial support from their respective communities for the expansion of facilities needed to meet the demands of the increased population.

A very small proportion of the total area of British Columbia is encompassed within municipal boundaries and the municipalities have not been required to contribute as generously to hospital costs as in other provinces, with the exception of the City of Vancouver and those few areas where the hospitals were municipally owned. Under the regulations of the Municipalities Act, each municipality is supposed to care for its poor and destitute citizens; but this section of the Act has not been invoked in regard to hospital care for indigents. Generally, statutory grants had been used to reduce charges to patients rather than as a means of providing reserves for bad debts and free work. Thus, it was expected, and has been proved, that community interest would increase and more beds and better equipment would be provided for the hospitals if basic costs were provided by the Insurance Service.

The determination of medical indigency and the financial arrangements for the care of indigents has long been a problem in hospital economy and it was felt that such cases would be reduced to a minimum by the introduction of compulsory insurance and payment at full rates for patients in receipt of social assistance. (The results of this program show that less than 4 per cent of all patients hospitalized for acute care can now be classed as indigents by the hospitals.)

In summary, it can be briefly stated that the aims of the British Columbia Hospital Insurance Service were to:

(a) give full protection to all acutely ill patients;

(b) provide adequate operating income for the hospitals;

(c) strengthen community interest in the hospitals;

(d) expand hospital facilities;

(e) minimize the volume of care for medical indigents;

(f) preserve the autonomy of the hospitals; and

(g) wield a benign influence in assisting hospitals with their immediate problems.

The last aim listed has been achieved in three and a half years of experience. Government officials have never hesitated to send a field man out to assist a hospital requesting advice. At the same time, there is no evidence to show that the government officials have used a heavy hand in dealing with hospital boards of management. On the contrary, the structure of hospital boards of management remains unchanged and members of each community still retain control of the operation of the hospitals by the appointment of board members.

Benefits

Each hospital is required to provide necessary public ward facilities and such operating room and delivery room facilities, x-ray and laboratory diagnostic and therapeutic procedures, anaesthetics and other services, dressings and drugs, as are prescribed by the regulations under the Hospital Insurance Act. In addition, beneficiaries receive out-patient services for accidental injuries, including x-ray, et cetera, for a flat rate of $2.00, provided that the service is rendered within 24 hours of the accident, or for minor operations which could not be performed in a doctor's office. Costs allowed to hospitals also include an amount to cover bad debts.

The actual interpretation of benefits has been to the effect that all services normally rendered to acute patients prior to the advent of hospital insurance have been covered by the B.C.H.I.S., plus the same out-patient benefits which had been covered by Blue Cross. If a hospital desires to expand its services it may do so from its own funds or by funds provided by the B.C.H.I.S., if the plans for expansion are approved in the annual budget. This has not affected the autonomy of the hospitals but it does give some measure of control to discourage unnecessary expansion or "frills".

All of the hospitals in British Columbia operate on an inclusive rate plan such as that established in Connecticut some years ago. The per diem rate, which appears high, includes ward fees, special services, some out-patient expense and an allowance for bad debts and free work. From this it will be seen that the rate paid to hospitals by the Insurance Service is equal to costs plus regular statutory grants, as found in other provinces.

Items which are not covered by the B.C.H.I.S. are cortisone and its derivatives, fees for the reading of electrocardiograph tracings, radium treatments, fees for anaesthesiologists, transportation, and out-patient services other than those for accidental injury.

Earlier in this article it was stated that the compulsory hospital insurance scheme tended to stimulate the development of hospitals, and this has proved to be so. Hospitals, usually with the approval of the B.C.H.I.S. have added electrocardiograph machines, equipment for physical medicine, better operating room lights, improved dietary services, premature nurseries, piped oxygen, and much modern equipment. The people of the province are receiving a better service than ever before and it is bound to continue to improve. The total number of beds in the province has been increased to meet the need at a rate which would have been impossible under previous arrangements and this expansion of facilities is increasing.

After two and a quarter years of operating the B.C.H.I.S., the government introduced an amendment to charge co-insurance at varying rates for the several classes of hospitals, but in no case was co-insurance to exceed $35 for any one family in a given year. This was a jarring note and was not well received by the political opposition, the labour unions, and several other groups; yet collections have been in excess of 80 per cent, with little objection from the patients. The position of the hospitals with regard to co-insurance has been difficult to interpret. Some are in favour and some against—some apparently don't care. Personally, the writer believes that co-

(Continued on page 86)

Lively Talent Displayed at

Physicians' Art Salon

"River Flats" by Dr. A. D. Bechtel, Victoria, B.C.

IN a sparkling setting, with the Canadian Rockies as an unrivalled backdrop, the 1952 Physicians' Art Salon was held last June, in conjunction with the Canadian Medical Association convention, at Banff, Alberta. This salon was the largest and most successful in the eight-year series, sponsored by the pharmaceutical firm, Frank W. Horner Limited, Montreal, P.Q.

The exhibition, located in the spacious Riverview Lounge of the Banff Springs Hotel, was thronged continuously with appreciative visitors. Especially popular was the Palette Club Display, where first prize winners in previous salons exhibited their latest creative efforts in the fields of fine art and photography. Palette Club members do not participate in the general competition.

The jury of selection this year included three well-known men in the world of art and photography. They were: W. J. Phillips, outstanding Canadian engraver and water-colour artist; Nicholas de Grandmaison, renowned for his pastel portraits; and George Nobel, famed for his photographs of the Canadian Rockies, especially in the Banff area. They had the tremendous task of choosing prize and award winners from 150 fine art entries, 80 monochrome photograph entries, and 550 colour transparencies. So enthusiastic were they about the calibre of the entries, that they issued a spontaneous joint statement at the conclusion of the judging, complimenting all entrants.

Prizes were awarded as follows:

Fine Arts

First Prize
Dr. A. D. Bechtel, Victoria, B. C.
"River Flats"

Second Prize
Dr. T. E. Brown, Lethbridge, Alta.
"Abandoned"

Third Prize
Dr. A. E. Robertson, Tranquille, B.C.
"Portrait—Peggy"

Awards of Merit
Dr. J. C. Callaghan, Toronto
"Rocky Coast"
Dr. W. D. S. Cross, London, Ont.
"Deep Pool"
Dr. F. D. Locke, Lacombe, Alta.
"Cloud Shadows"
Dr. P. Mari, Ninette, Man.
"A Chinese Scholar"
Dr. R. Campbell Ower, Montreal
"Paediatric Reconstructed Surgery"

"The Pottery Market" by Dr. C. M. Spencer, Toronto, Ont.

(Concluded on page 112)

Highlight in a Hospital's History

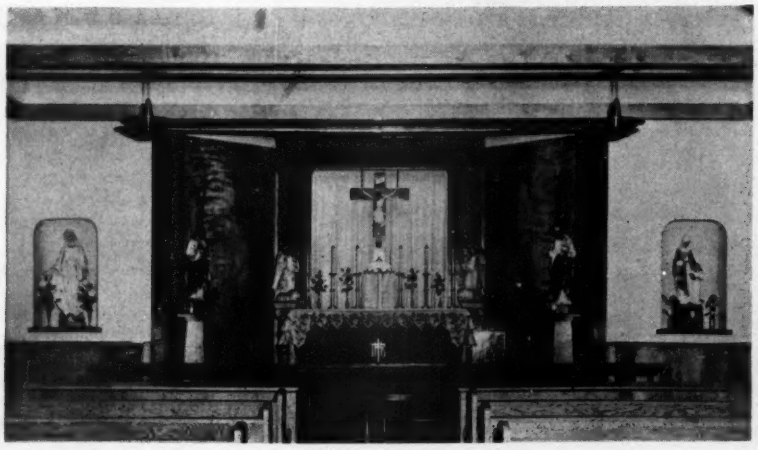
St. Joseph's Hospital, Vegreville, Alta.

IN October, 1951, the new wing of St. Joseph's Hospital, Vegreville, Alta., was officially opened, completing another chapter in the hospital's history. In 1910, four Sisters of Charity of Our Lady of Evron, France, came to Vegreville to open the hospital so urgently needed in the district. Of these four, only Sister Superior, belovedly known as Sister Josephine, is still active. In 1915, a school of nursing was opened and gained official recognition in 1918 when the first two students completed the course. Today, the school has 40 students in training.

Since its opening, St. Joseph's General Hospital has been enlarged three times. In 1934, a wing was added and, in 1937, a second wing was built. With the latest addition, opened in 1951, the hospital has increased its bed capacity to 85 and the number of bassinets to 15. Renovation was carried out in the older part of the building as well, so that today St. Joseph's is even better prepared and equipped to care for the sick of the district which it has served since 1910.

The New Wing

In the basement of the new wing are improved living quarters for the staff, comfortable bed rooms, a recreation room, and dining rooms. On the first floor, a beautiful chapel affords a peaceful atmosphere, so ap-



The lovely chapel, a place of peace and prayer

preciated by both visitors and hospital personnel. On this floor also is a spacious community room for the Sisters.

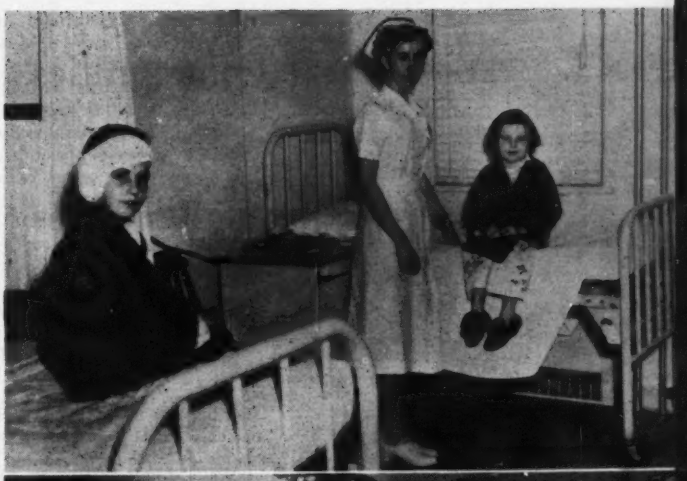
The entire second floor houses new paediatric facilities which include three semi-private rooms, one 4-bed ward, and a paediatric nursery with eight cribs. There is an isolation nursery formula room, and two bathrooms. Oxygen is piped to all wards from the central stores. The paediatric nursery has eye-catching linoleum of Donald Duck design, and coloured venetian shades on the windows. Cribs are, alternately, blue and pink.

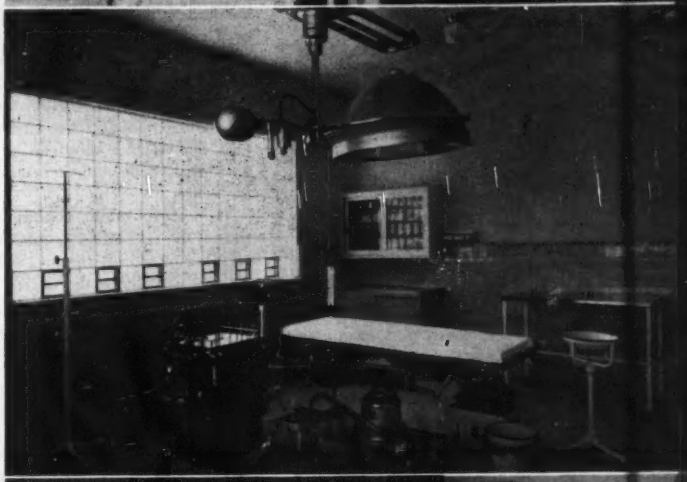
In the older part of the hospital, the second floor was completely revamped, to give airy private and semi-private rooms, and wards.

The third floor of the new wing is occupied by one minor and two major operating rooms, with piped-in oxygen, and nitrous oxide. Ample space for the scrub room, sterilizing room, supply rooms, and plaster room, helps to avoid confusion and promotes good surgical technique. Where the operating rooms had been located in the main building are now a new central supply room and a spacious laboratory. Nearby is the blood bank refrigerator.

Maternity care was improved with the finishing of a two-bed labour room, and a large up-to-date case room. The nursery has been modernized also and has piped-in oxygen.

At the opening of the new wing in Oct. 1951, there was a large gathering, including visiting dignitaries and older citizens who had been present at the opening of the original hospital in 1910. Speakers included members of the clergy, representatives of the provincial government, and members of the medical staff. It is interesting to note that one speech was delivered in French and one in Ukrainian. Ladies of the hospital auxiliary served tea to the visitors and Rev. Sister Superior and her staff conducted guests on a tour of the hospital.—*H. Couillard, M.D.*





Above: *These two appealing youngsters look as if they are enjoying the new paediatric facilities at St. Joseph's.*

Centre: *One of the new operating rooms.*

Below: *The nursery has been modernized. Note the self-contained mobile cubicle units.*

Educating Rural Communities in the Use of Hospital Services

Vera B. Eidt,
Superintendent,
Trail-Tadanac General Hospital,
Trail, B.C.

REPRESENTING a community which has always enjoyed a plan of pre-paid hospital and medical care, I can say that the citizens of our area "love their hospital". They have a full realization of the benefits which it has to offer and an appreciation of the services rendered. Scarcely a week goes by without notification, through the local newspaper, from grateful patients thanking the hospital for the attention given to them or to their families. With the foregoing in mind, I shall attempt to discuss this subject from the viewpoint of how to educate patients to use their hospital intelligently and how to show them that they may derive the greatest benefit from the services which hospitals have to offer.

A district for hospital service has been defined as follows: "An area from which families seek the larger centre for such special services as, ready-to-wear clothing, the social services of a hospital or clinic, the educational service of a normal or technical school, the sociability of a good motion picture house, a musical concert, or a dramatic performance."

Much has been said about the ideal ratio of rural to urban population, *e.g.*, that the physical standards of the race depend largely upon it, ratios varying in studies made of several countries from 1-1 to 1-5. It is agreed that something between the two should be the objective.

For our purpose we might well use the figures of a recent study using 15,000 or less as a criterion for a rural hospital district. It is difficult to determine what pattern of hospital service is necessary for any given district or whether any given formula is workable until an analysis has been made of the existing kinds of rural population, present hospital facilities in the given district, and how the deficiency can be made up. It may be found that a considerable percentage of the population is already served by existing hospitals. This may be of importance or it may be of little importance, until the following facts are ascertained: (1) where these hospials are; (2) how good they are; (3) whether the people have convenient access to any hospital; also (4) whether they can be reasonably assured of competent and intelligent care.

If unfavourable conditions are found, the first thing people are likely to think of is building a new hospital. This is sometimes the easiest way to alter a situation. A new building lifts morale. It may be found that a new structure is badly needed—but there are other means by which hospital service can be improved. It has been said that "a good record librarian may do more to raise the level of medical care than a new operating room". Communities might be well advised to overhaul the hospitals they have or enter into negotiations with their neighbours for a joint project.

A single hospital placed at a natural rural centre, for a given population can render as good service as one in a city serving the same number of people. Such hospitals would tend to attract and hold competent physicians who have abandoned rural communities for the better facilities offered by city hospitals. The quality of medical care would be kept at a higher standard, through staff membership, the use of hospital facilities, and the knowledge gained through staff conferences. An attractive hospital will tempt young men back to rural communities, thus providing adequate care for the sick of the region.

Rural Difficulties

If we are agreed that good hospital and medical care can be given to rural areas with an approximate population of 15,000 persons, let us review some of the difficulties which may be encountered. These are higher costs, limited resources, and sparse or scattered population.

Costs will be higher because of the relatively small number of cases per practitioner in sparsely settled areas, distance will prevent the effective use of the practitioner's time, because he must travel to outlying districts to render service. Limited resources, in some areas, mean limited income to many persons. The cost of rendering medical care to remote areas should not be a charge laid upon medical practitioners as in the past.

Some means of bringing patients from outlying areas to medical centres would seem to be the logical solution. If rural people wish to have the advantage of good medical care they must be prepared to go to a hospital large enough to provide that care. This will mean that it may be necessary to bypass the attractive small hospital in their immediate neighbourhood. Good roads, ambulance service, including air ambulance, and first aid service, will prove of more value than small local hospitals in emergencies.

This, then, is where our educational program must commence.

Education

The human element must not be overlooked. Due to the very nature of individuals, persuasion usually has better results than coercion. Nor must we overlook the principles of community pride; their viewpoints and sentiments must be given sympathetic consideration. Every individual is a conveyor of good or poor public relations—the builder, in this instance, of good or poor health service. Some means of conveying to the people what is meant by good medical and hospital care must be formulated. This can be done best by arranging a well-planned program. Leading citizens in a given region are usually aware of the needs of their own area, and so such a program should be handled from the local or regional level. There are a variety of ways in which this may be accomplished. Leaders in any community or region could be enlisted, on a voluntary basis, to outline the needs of the community, and how these could be co-ordinated to the best advantage from the service and economic

An address presented at the hospital sectional meeting of the American College of Surgeons, Vancouver, B.C., March, 1952.

standpoints.

As a natural sequence, people turn to hospitals, hospital boards, and physicians, for information. Every employee of a hospital should be a transmitter of the right type of public relations. The satisfied patient is the best advertising agent the hospital and community can possess.

There are many other ways in which information may be taken to the outlying areas. In this present era, in which we are privileged to live, communication is rapid. Radios are now the accepted medium rather than the exception in most remote households. Other means are the visual method, the use of slides and films in the home or through the local movie house, through newspapers and last but not least, by word of mouth. I believe there are few urban people who do not, at some time, spend their vacation in some rural isolated spot where, after a day's fishing or hunting, they may find themselves ensconced in their wilderness cabin exchanging stories with guides or local people, or meeting the rural citizens in the wayside inn, or general store. The lonely fire ranger in his lookout, the Mountie in his treks through the hinterlands of these vast provinces have contacts which are few and far between but of inestimable value, for their listeners are an eager and receptive group. They are eager to hear news of what is transpiring in the outside world. In the more inhabited rural districts, local clubs, women's auxiliaries, churches and schools are an important liaison as an educational group.

It is important that these individuals and groups be co-ordinated with a central program committee in order that the information given may coincide with the acceptable method of teaching.

Now that we have outlined some of the means by which to reach the local population, let us deal next with intelligent application.

Knowledge of First Aid

Every individual should have some knowledge of first aid. This may be inbred in some persons. Even the most primitive people exercise a very crude type of first aid with good results. First aid teaching could well be incorporated in an elementary school curriculum. Early training has a way of remaining fixed in one's mind and is usually remembered when an emergency arises. Certain signs and symptoms should be easily recognizable. It would assist greatly in eliminating needless, long and expensive trips in some cases, if one were able to distinguish the less seriously ill from the seriously ill, and to decide whether or not the patient should be transferred to a first aid post, a small local hospital or directly to the medical centre. The fundamental knowledge of first aid, the first aid post, and the local hospital, should act as clearing houses for the sick or injured person before the longer trip is made to a more highly specialized centre.

Transportation

We are immediately faced with the problem of transportation and economics. Where industry has been established the cost of transportation is usually provided. In the case of a small community the citizens usually group together, supplying the necessary money and providing transportation. The Red Cross stands ready to assist, as does the Department of Health and Welfare in needy cases. Communication and advance notice to the medical centre is of utmost importance, particularly if a number of patients are involved. It gives the hospital staff time to prepare, and be in readiness when patients arrive. This is especially true in this day of overcrowded hospitals and bed shortages. It may mean discharging some patients to their homes and the shifting of beds to provide the necessary space, which all takes time. Too frequently is this all-important point overlooked.

Under any prepaid medical plan, careful screening of all cases is necessary in order that valuable bed space is not utilized unnecessarily. This can only be done by the group of physicians working in the hospital. A word should be said here about preventive medicine, which can be taught by public health officers in rural areas. Included in any educational program should be instruction in the value of innoculation against certain types of communicable disease.

Women's Auxiliaries

Women's auxiliaries to hospitals should, I feel, have special mention. They are more than a group of women

(Concluded on page 118)

For graceful blooms like these next spring, plant bulbs now. See page 64.

Canadians Honoured at A.C.H.A. Convocation

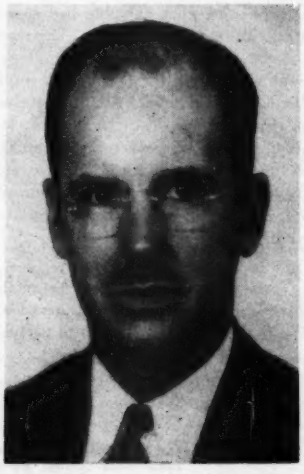
THE 18th annual convocation of the American College of Hospital Adminstrators took place in Philadelphia, Pa., on Sunday, September 14th, with appropriate ceremony and formality. Over 90 candidates were advanced to fellowship, approximately 210 others to membership and 278 nominees were admitted—a record number in the annals of the College. Among this large group were 35 Canadians.

Fraser D. Mooney, M.D., President-elect of the College, presented candidates for admission and advancement while certificates were conferred by President Ernest I. Erickson. Following the impressive convocation ceremony, newly inducted members were invited to a reception given by the officers and regents of the College. On Sunday evening, the annual banquet was held in the Benjamin Franklin Hotel. Mr. Erickson presided over the dinner program and presented the president's message, the principal event of the evening. Frank J. Walter, administrator of the Good Samaritan Hospital, Portland, Ore., and immediate Past President of the A.C.H.A., was presented with the Past President's badge.

At the educational session held on Monday, Clark G. Kuebler, Ph.D., president of Ripon College, Ripon, Wis., gave the Arthur C. Bachmeyer annual address. In speaking of education and man's quest for freedom, Dr. Kuebler stressed the importance of educating professional people in the liberal arts as well as in vocational training.

After this address, the general business session was held and officers were elected for the coming year. Dr. Merrill F. Steele, superintendent of The Christ Hospital, Cincinnati, Ohio, was chosen as the new president-elect and other officers elected were: Fraser D. Mooney, M.D., director of the Buffalo Hospital, Buffalo, N.Y., president; Ernest I. Erickson, immediate past president; Melvin Sutley, first vice-president; Sister M. Conchessa, second vice-president.

Donald M. Cox, Victoria, B.C.



L. N. Hickernell, Vancouver.

Canadian Members and Nominees

There were many Canadians present at the convocation ceremony. Following is a listing of the 35 who were admitted or advanced in rank.

Advanced to Fellowship

Sister M. Berthe Dorais, administrator, St. Boniface Hospital, St. Boniface, Man.

Donald M. Cox, assistant commissioner in charge of hospital services, BCHIS., Victoria, B.C.

Gordon A. Friesen, Washington, D.C., formerly administrator, Kitchener-Waterloo Hospital, Kitchener, Ont.

Leon N. Hickernell, director, Vancouver General Hospital, Vancouver, B.C.

Advanced to Membership

L. Reginald Adshead, assistant superintendent and business manager, University of Alberta Hospital, Edmonton, Alta.

J. L. Murray Anderson, M.D., assistant administrator, Royal Jubilee Hospital, Victoria, B.C.

George J. Bartel, superintendent, St. Mary's Hospital, Montreal, P.Q.

Rahno M. Beamish, superintendent, Sarnia General Hospital, Sarnia, Ont.

H. H. Browne, superintendent, Reddy Memorial Hospital, Montreal.

Sister Gertrude Jarbeau, assistant administrator, St. Boniface Hospital, St. Boniface, Man.

Sister Jeanne-Mance, supérieure, Hospitalières réligieuses de St. Joseph, Montreal.

L. F. C. Kirby, director, Royal Columbian Hospital, New Westminster, B.C.

Carman J. Kirk, M.D., superintendent, Victoria Hospital, London, Ont.

Donald M. MacIntyre, assistant secretary, Canadian Hospital Council, Toronto.

Sister Marie de Loyola, administrateur générale, Sacré-Coeur, Montreal.

Sister Mary Ruth Ross, administrator, St. Vincent's Hospital, Vancouver.

Sister St. Joseph, administrator, Hôtel-Dieu de Sorel, Sorel, P.Q.

Dora E. Shrimpton, assistant superintendent, Toronto Western Hospital, Toronto.

Sister Vera, assistant administrator, St. John's Convalescent Hospital, Willowdale, Ont.

(text concluded on page 48)

Sister Marie de Loyola,
Montreal.

Sister Ste. Agathe de Jésus,
Levis, P.Q.

C. J. Kirk, M.D.,
London, Ont.

G. J. Bartel,
Montreal.

Sister Vera,
Willowdale, Ont.

Rahno M. Beamish,
Sarnia, Ont.

Sister Jeanne-Mance,
Montreal.

Sister St. Joseph,
Sorel, P.Q.

L. F. C. Kirby,
New Westminster.

J. L. M. Anderson, M.D.,
Victoria.

Sister Mary Ruth,
Vancouver.

A. C. H. A. . . . .

F. G. Hubbard,
Vancouver.

R. Ray Copeland,
Port Colborne, Ont.

Norman A. Brady,
Toronto.

Sister Ste-Solange,
Quebec City.

Gerald LaSalle, M.D.,
Montreal.

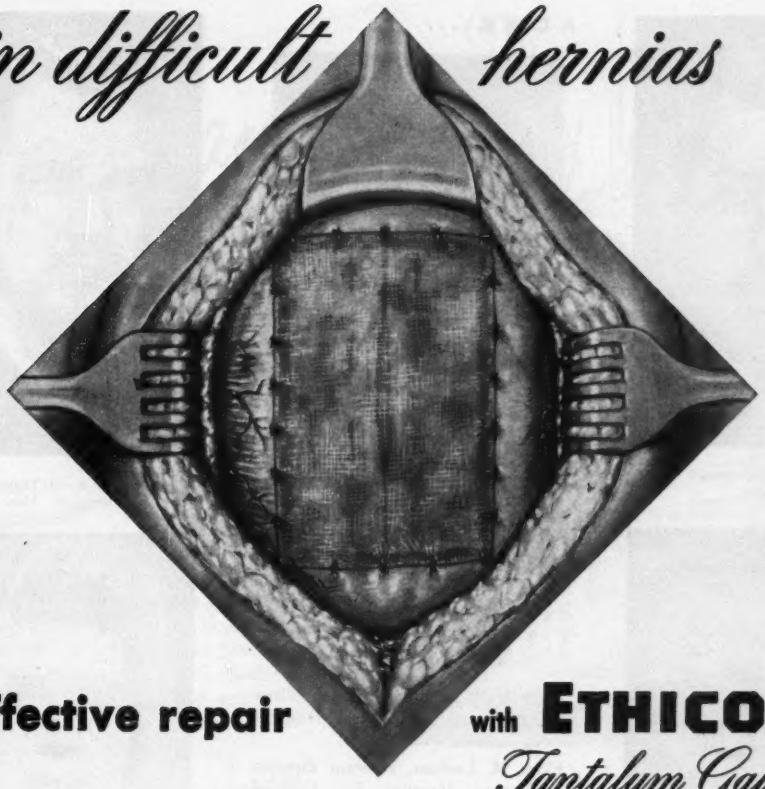
J. B. Neilson, M.D.,
Hamilton, Ont.

A. J. Thomson,
Toronto.

Sister Florence Mary,
Kenora, Ont.

Edwin V. Wahn,
Swift Current, Sask.

in difficult hernias



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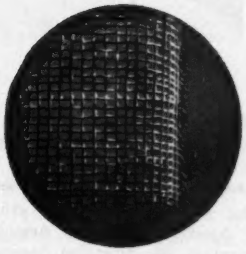

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Surgeons have found Ethicon TANTALUM GAUZE an effective and dependable material for repair of large and difficult hernias of many types, especially large ventral hernias where the attenuation of the tissue renders classical procedures ineffective. Made of .003" Tantalum wire and woven into a 50 x 50 screen, this soft metallic gauze provides a firm and usually permanent closure.

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- chemically inert
- non-irritating
- readily sterilizable

Ethicon Tantalum sutures are widely used in tendon and bone repair, in hernioplasties and laparotomies, and in neurosurgical procedures. Ethicon Tantalum Hemostasis Clips, Tantalum Skull Plate Screws, and Tantalum Foil, Sheet and Discs are standard materials in surgery of the head and face.

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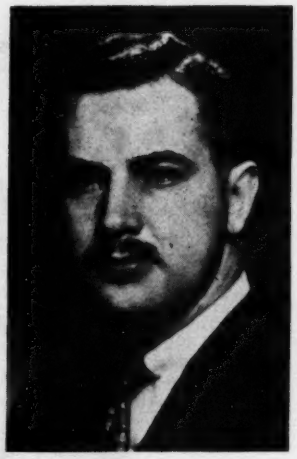
Weston, Ont.



Allan K. McTaggart,
Brandon, Man.

Sister Mary James,
Vancouver.

(text concluded from page 44)

Gerald La Salle, M.D., administrator, University of Montreal Hospital, Montreal.

Nominees

Norman A. Brady, hospital manager, Sunnybrook Hospital, Toronto.

R. Ray Copeland, administrator, Port Colborne General Hospital, Port Colborne, Ont.

Sister Florence Mary, administrator, St. Joseph's Hospital, Kenora, Ont.

Sister M. Honora, assistant superintendent and secretary, St. Joseph's Hospital, Winnipeg, Man.

Frederic G. Hubbard, assistant director, Vancouver General Hospital, Vancouver.

Flora M. Lamont, assistant director, Shriners Hospital for Crippled Children, Montreal.

Sister Mary James (Mulvaney), business secretary and assistant administrator, St. Vincent's Hospital, Vancouver.

Sister Maura, superintendent, St. Michael's Hospital, Toronto.

Allan K. McTaggart, administrator, Brandon General Hospital, Brandon, Man.

John B. Neilson, M.D., superintendent, Hamilton General Hospital, Hamilton, Ont.

Sister Ste. Agathe de Jésus, administrator, Hôtel Dieu de Lévis, Levis, P.Q.

Sister Ste-Solange (Fouquet), administrator, Hôpital St. François d'Assise, Quebec, P.Q.

Arthur J. Thomson, acting bursar, Toronto Psychiatric Hospital, Toronto.

Edwin V. Wahn, administrator, Swift Current Union Hospital, Swift Current, Sask.

Clarence A. Wicks, M.D., superintendent, Toronto Hospital for Tuberculosis, Weston, Ont. ●

Dr. Harvey Agnew Active in Association of Hospital Consultants

On September 14th, just prior to the American Hospital Association convention, the American Association of Hospital Consultants held its annual meeting at the Sylvania Hotel in Philadelphia. Dr. E. M. Bluestone of Montefiore Hospital, New York City, was re-elected president for the coming year, with Dr. Basil C. MacLean, Strong Memorial Hospital, Rochester, N.Y., as vice-president. Jacques Norman of Greenville, S.C., continues as secretary-treasurer, while Dr. Harvey Agnew, Toronto, and Dr. Herman Smith, Chicago, were elected to the Executive Committee.

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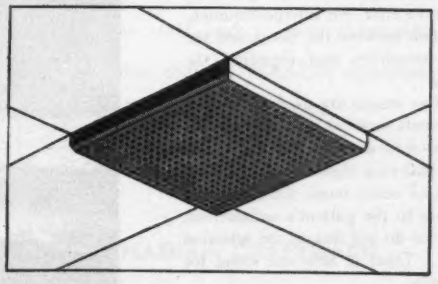

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The Merits of Completely Centralized Food Service

G. A. Friesen,* Washington, D.C.

IN PLANNING new hospitals there still appears to be considerable controversy regarding the merits of the centralized and decentralized system of food service and the many applications of these two systems. In a multi-storey building it would appear that the former system is preferable for the following reasons:

1. More economical in respect to equipment and personnel;
2. Less noise and fewer odours on wards;
3. Standardized portions and selective menus save food waste;
4. Fewer broken dishes;
5. More attractive trays and hotter food;
6. Fewer mistakes in getting the right food to the right patient;
7. More efficient use of ward space and nursing time;
8. Less handling of food and dishes.

A completely centralized system was adopted in the new Kitchener-Waterloo Hospital, Kitchner, Ontario, inasmuch as all food is prepared in the main kitchen including ice water, nourishments, et cetera. This automatically eliminates the need for floor pantries as the kitchen is staffed twenty-four hours a day and from there all requirements are delivered to the floors, ready to serve, by means of a dumbwaiter. An intercommunication system between the floors and the kitchen simplifies and expedites the ordering.

Selective menus are used. Obviously this prevents waste as the patient is not served food he does not like and allowing the patient a choice of food makes the service seem more individualized and more to the patient's satisfaction. Economics do not dictate the selection of food. There is only one menu for all patients.

The daily menu is made up of the selectives for lunch, dinner, and breakfast, and is sent to the patient the previous evening. Menus are returned to the kitchen by 10 a.m. on the day the lunch is to be served. These menus are then quickly summarized for the chef, baker, salad and dessert girls. In this way the food is never prepared hours before the meal is served. Incidentally, dinner served in the evening has proved very popular.

All the functions relative to the preparation and serving of food, dismantling trays, and washing dishes.

(Concluded on page 94)

Above: Belt assembly line on which all patients' trays are made up.
Below: Cafeteria has selective menus and all employees pay for meals.

** Until recently administrator of the Kitchener-Waterloo Hospital, Kitchener, Ontario, the author is now principal consultant in hospital administration to the three non-profit Memorial Hospital Associations of Kentucky, West Virginia, and Virginia, with headquarters in Washington, D.C.*

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Food and Its Service

Sponsored by The Canadian Dietetic Association

Spotlight on the C. D. A. Convention

Margaret R. McKellar, M.A.,
Faculty of Household Science, University of Toronto, Toronto, Ont.

THE beautiful campus of the University of British Columbia, Vancouver, provided a picturesque setting for the 17th annual convention of the Canadian Dietetic Association, held from June 10th to 13th. Attendance was excellent with representatives from many parts of Canada including Saint John, N.B.—a continent away.

The program covered a wide range of subjects and offered something of interest to those in every branch of the dietetic profession. One of the highlights was the Violet Ryley—Kathleen Jeffs Memorial Lecture which was given this year by Florence Reynolds, North American Information Officer of the United Nations Food and Agriculture Organization. Miss Reynolds quickly captured the interest of the audience and held her listeners spellbound throughout the lecture. We were made acutely aware of the hunger existing in the so-called "have not" countries. It was alarming to hear that two-thirds of the world's people were hungry and that half of the world's population had reached starvation point. The only encouraging note in the food situation of today seems to come from the experts who, after a thorough study of all possibilities, have decided that even without extending the land under cultivation it should be possible, by education and by improved methods of production and distribution, to feed the entire world population. This is one of the tremendous problems with which FAO is grappling.

Each year a luncheon is held for the exhibitors as a gesture of appreciation to those who contribute so greatly to the success of the convention. At the luncheon, this year, the acting mayor, Mrs. Sprott, brought greetings from the city of Vancouver. The speaker, Dick Diespecker of the *Vancouver Daily Province*, chose the provocative title "British Columbia—the Place We Choose to Live". We were taken on an imaginary tour to see the particular beauties of each part of the province and were given a brief history of British Columbia in an address which sparkled with wit and humour.

Two of the sessions were in the form of group presentations both of which proved extremely successful. The first one, "Recent Trends in Food Processing", was chaired by Dr. Blyth Eagles, Dean of Agriculture, University of British Columbia. F. E. Atkinson, a horticulturist at the experimental station, Summerland, B.C., explained that whereas clear apple juice may or may not be fortified with ascorbic acid, the opalescent juice has to be fortified to prevent darkening by oxidation. He mentioned that frozen prunes were highly satisfactory as long as they were not allowed to thaw before cooking. A new product, Jonathon apples, in a 30 to 35 per cent syrup pack, was described as being very attractive. It will be available soon on the market. P. A. Sunderland of the B.C. Packers Ltd., Steveston, B.C., was enthusiastic on the subject of fish, pointing out that although soils may become depleted, oceans never do. He spoke of the high content of essential amino acids in fish protein and the high vitamin value of the liver and kidney of fish. He pointed out that improved methods of refrigerated transportation have made sea food available to many and that dipping fillets in ascorbic acid prevents rancidity due to oxidation. Both these factors, he felt, have helped to maintain freshness of flavour. V. Pinchin, of Canada Safeway Ltd., Vancouver, described several new developments in the curing of bacon and packaging of meats for the retail market. Dr. Anstey, a horticulturist at the experimental farm, Agassiz, B.C., spoke of the importance of choosing the right variety and quality of vegetables for frozen products. An interesting point which he brought out was the relationship between specific gravity and the cooking quality of potatoes. He explained how potatoes are graded according to bakers, fryers, and so on. Neil Gray of the Fraser Valley Milk Producers' Association, Vancouver, reminded the audience that 45 per cent of Canada's cottage cheese is produced in British Columbia. He pointed out that low fat milk is on the market at a lower price, described the concentrated fresh milk available in the United States, and extolled the value of skim milk powder. The last speaker on the panel was Professor A. E. Lloyd, department of poultry husbandry, U.B.C., who told of the work done in his department toward producing junior-sized turkeys for smaller families. He said also that chickens with the greatest flavour were birds so bred as to weigh 3½ to 4 lbs., by 11 weeks of age.

In the other group presentation, a therapeutic team from the Vancouver General Hospital discussed three actual cases, with the doctor, nurse, social worker, and dietitian each describing a particular treatment given. In every case, it was stressed that these three services—medical, welfare, and dietetic—must work together as a team. It was a most interesting session, well handled by Dr. D. S. Munroe.

At one of the general sessions, Squadron Leader Agnes Campbell of the R.C.A.F., Lachine, P.Q., described some of the feeding problems in isolated stations. Marjorie Evans of the Coqualeetza Indian Hospital, Coqualeetza, B.C., told of her attempts to include native dishes on hospital menus (see *The Canadian Hospital*, Sept., 1952); and Mary Macbeth, chief

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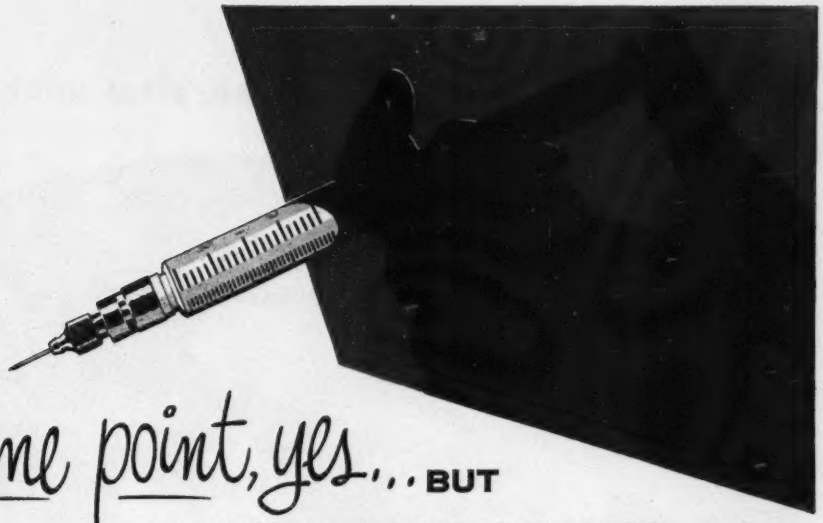

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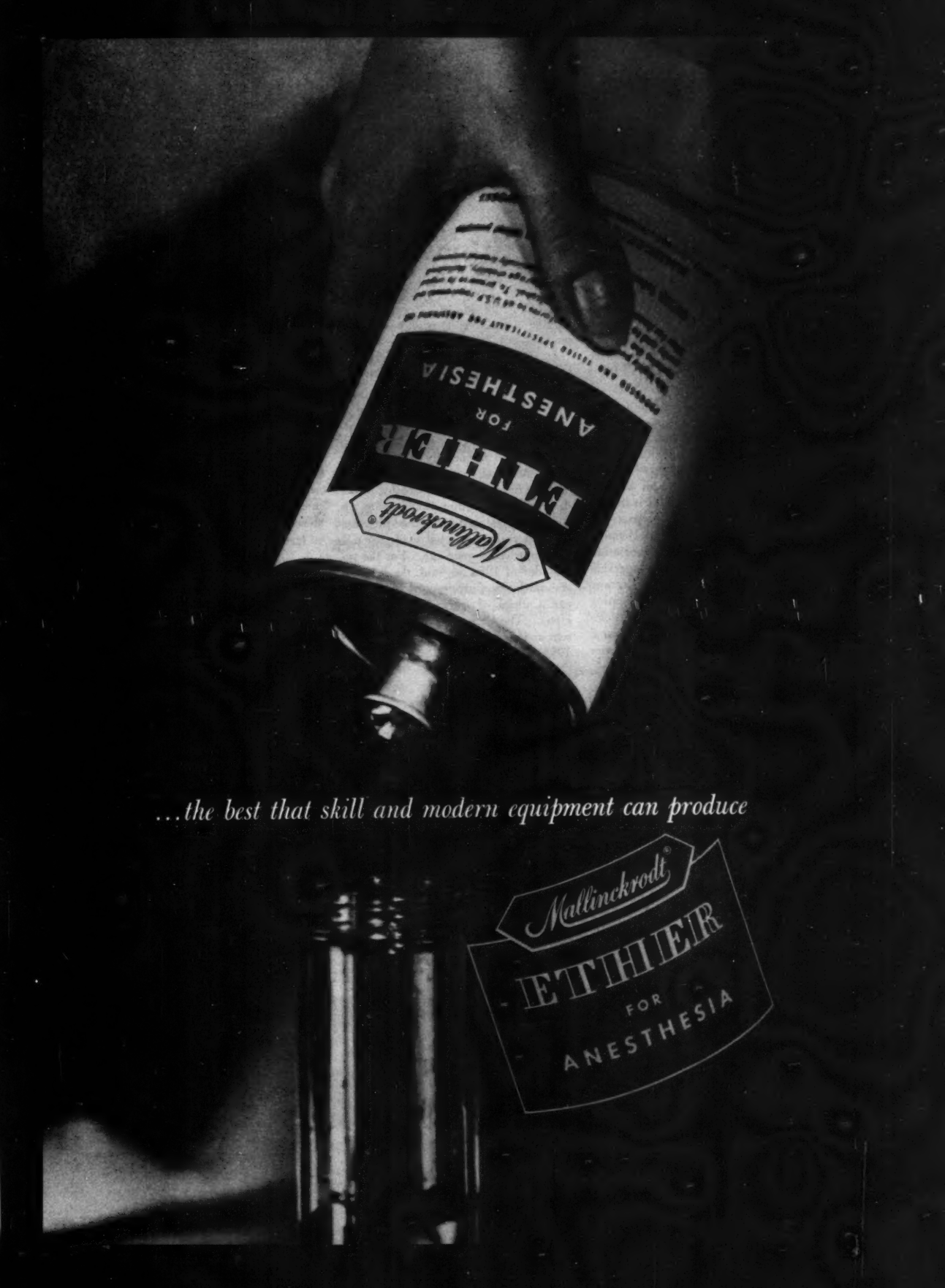
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Another Chapter in Philadephia's Story

THE City of Philadelphia, steeped in American history, proud of its Pennsylvania Hospital founded by Benjamin Franklin, its four medical schools, independence hall, and its liberty bell, played host to the 54th annual convention of the American Hospital Association, held from Sept. 15th to 19th. Over 10,000 delegates and exhibitors were registered at this mammoth convention — an all-time high. Meeting in conjunction with the A.H.A. were five allied organizations, the American Association of Hospital Consultants, the American Association of Nurse Anesthetists, the American College of Hospital Administrators, Association of Hospital Planning Agencies, and the Hospital's Industries Association, while the A.H.A. National Committee on Women's Auxiliaries held its fifth annual conference.

There were two innovations on the program of this year's convention—for the first time, panel discussions took the place of prepared addresses in many of the general sessions, and trustees were represented, taking part in the session devoted to administrator-governing board relations. Themes pointed out the aim of each general session and some of these were: a view of the future, national programs of interest to hospitals, it takes everybody to run a hospital, and leadership in administration. On the last day, concurrent sessions were held, including a joint meeting with the women's auxiliaries. At other concurrent sessions, participants pondered how best to stretch the hospital dollar, considering the question from the viewpoint of self-evaluation, economy of purchasing and design, cutting operating costs, additional income dollars, nursing evaluation and extending third party payments. An amusing and clever gimmick helped to advertise these meetings. Readily available, were small rubber objects about the size and shape of a dollar bill and possessing great stretching as well as advertising power. Bearing the A.H.A. crest, with wishes for good luck and economy, these rubber "snapificates" humourously called attention to the "stretch your hospital dollar" sessions.

Matters of Importance

In his report to the House of Delegates, President Anthony J. J. Rourke, M.D., painted a generally bright picture of the Association's past year and immediate future. Edwin L. Crosby, M.D., director of the Joint Commission on Accreditation, outlined the progress this new commission has made since it was approved a year ago. For the remainder of 1952, he said, the hospital standardization program of the American College of Surgeons will be in effect. The College's point rating system and standards will also be used in 1953 and thereafter will be studied for desired changes.

An important matter which was given final approval at this year's convention was the plan to establish an Institute of Hospital Affairs—a proposal which has been under consideration for about a year. This Institute is envisioned as an educational and research centre for the hospital field and would be in close affiliation with a university. It would be established with the financial aid of a foundation (as yet anonymous) who would donate funds to be used to erect suitable facilities and to finance operation for the first five years. In case such financing is not forthcoming, the House of Delegates suggested that plans should be made in the year ahead to develop alternate methods. This Institute would seek to relieve hospitals individually of the financial and personnel strain of conducting studies in all aspects of hospital operation, provide a demonstration and testing centre for curriculum planning of all university courses in hospital administration, and to increase and improve the number and quality of short courses for training those concerned with administration of all levels of hospital operation.

Edwin L. Crosby, M.D.

Dr. Crosby, now president of the American Hospital Association, is executive director of the new Joint Commission on the Accreditation of Hospitals.

In another major action, the House of Delegates affirmed its support of the principle of accreditation of schools of nursing but voted to review the accreditation program of the National Nursing Accrediting Service to determine if it is the most effective organization for implementing accreditation of schools of nursing. The National Nursing Accrediting Service was established, recently, by the national nursing organizations and in August it published a list of approved schools, omitting 276 hospital schools of nursing and giving 600 schools only temporary accreditation.

And Over and Above . . .

Besides the addresses and discussions, there were many other features to attract the interest of delegates to this 54th annual convention. The Hospital Merchandise Mart stretched over a vast area in the convention hall and displayed over 600 commercial and educational exhibits. Other outstanding events included an address by the President of the United States, Harry S. Truman, who spoke at the federal hospital executives' luncheon, a cruise on the Delaware River, a radio broadcast, an interview of the Association president on television, the conclusion of the "Stretching Your Hospital Dollar" contest, the annual banquet, and various interesting films. A special session was the radio program, "Am-

(Concluded on page 102)

welcome delegates . . .

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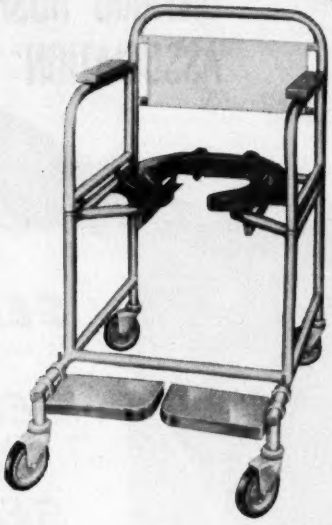

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Nouveaux Officiers au

Conseil des Hôpitaux Catholiques du Canada

LORS de son assemblée annuelle tenue à Sudbury, Ont., au début de l'été, le Conseil des Hôpitaux Catholiques du Canada adopta une nouvelle Constitution par laquelle un président était élu pour un terme d'un an et un secrétaire-administrateur permanent était nommé. Monsieur l'abbé J. G. Fullerton, de Toronto, fut élu président pour l'année 1952-53 tandis que le Père Henri Légaré, Docteur en Sciences Sociales, de Winnipeg, fut nommé administrateur.

Le Conseil tient à exprimer sa plus sincère gratitude au Révérend Père Hector Bertrand, s.j., pour son zèle infatigable à la cause des le hôpitaux catholiques. Durant sept ans il dirigea avec compétence le C.H.C.C.

M. l'abbé J. G. Fullerton est Directeur des Oeuvres de Charité de l'archidiocèse de Toronto, membre du Bureau de Direction de l'Association Hospitalière de l'Ontario, et membre du Bureau de Gestion du Plan de la Croix Bleue pour l'Ontario. Il est aussi président du Bureau de Direction de l'hôpital St-Joseph, de Toronto, le représentant des evêques pour l'Ontario dans le C.H.C.C., et Directeur spirituel de la Conférence Ontarienne des hôpitaux catholiques. M. l'abbé Fullerton est certainement bien qualifié pour assumer la présidence du C.H.C.C.

Le Révérend Père Légaré suivit des cours en sciences sociales à l'Université Catholique de Washington et à l'Université Laval d'où il obtint sa Maîtrise. Il poursuivit ses études en Sciences Sociales à Lille, Paris, et Fribourg. C'est de Lille qu'il obtint son Doctorat en Sociologie. Jusqu'à sa nomination au poste de Secrétaire-adminstrateur du C.H.C.C. le P. Légaré enseignait à l'Université d'Ottawa et au Grand Séminaire de St-Boniface, Man., il était membre du bureau de rédaction de la "Liberté et le Patriote", de Winnipeg, Man., et membre de plusieurs agences de service social. En plus, il était membre du Bureau des Aviseurs de l'Hôpital de St-Boniface et du Manitoba Health Survey Committee.

Les autres officiers du C.H.C.C. pour l'année 1952-53 sont les suivants:

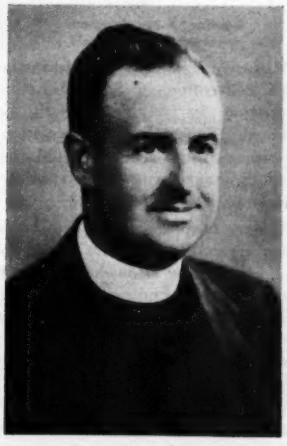
Iére Vice-Présidente: Mère M. Mann, 1190 rue Guy, Montréal, P.Q.

2ième Vice-Présidente: Soeur Béatrice, Hôpital St-Michel, Lethbridge, Alta.

Secrétaire: Mère Margaret, Hôpital St-Michel, Toronto, Ont.

Trésorière: Soeur Joseph-Edmond, Hôpital Général, Ottawa, Ont.

Deux autres membres complètent le Comité Exécutif du C.H.C.C.: Mère Maître, Hôtel Dieu, Windsor, Ont.; Soeur Pulcheria, Hôpital St. Elisabeth, Humbolt, Sask.



M. l'abbé J. G. Fullerton, Président, C.H.C.C.

* * * *

New Officers of the Catholic Hospital Council

At its annual meeting held in Sudbury, Ont., this summer, the Catholic Hospital Council of Canada adopted a new constitution featuring the appointment of a president elected for a one-year term and a permanent executive director. Rev. John G. Fullerton of Toronto was elected president for the curent year, while Rev. H. F. Légaré, O.M.I. of Winnipeg, Man., was appointed to the post of executive director.

In announcing the new officers, the Catholic Hospital Council of Canada expressed its deepest gratitude to Father Hector L. Bertrand for his untiring zeal and his most competent work during the past seven years as president. His task has been constructive and enlightening and the C.H.C.C. feels deeply indebted to him.

The new president, Rev. John G. Fullerton, is the Director of Catholic Charities for the Archdiocese of Toronto, a member of the Board of Directors of the Ontario Hospital Association, and a member of the Board of Management of the Blue Cross Plan for Ontario. He is also chairman of the Board of Directors of St. Joseph's Hospital, Toronto, the Bishops' Representative for Ontario on the C.H.C.C., and the Spiritual Director of the Ontario Catholic Hospital Conference. Father Fullerton is thus well qualified to assume the presidency of the C.H.C.C.

The new executive director, Rev. H. F. Légaré, O.M.I., obtained his Master's Degree in social sciences from Laval University, Quebec, P.Q., and later studied at Lille, Paris, and in Fribourg, Switzerland. While at Lille, he took his doctor's degree in sociology. Prior to his new appointment, Doctor Légaré taught sociology at the University of Ottawa, Ottawa, and at St.

(Concluded on page 122)

Le Révérend Père H. Légaré, Administrateur, C.H.C.C.

O. H. A. Convention Forecast

WITH the theme of "Our Hospital Today and Tomorrow", the 28th annual convention of the Ontario Hospital Association will be held at the Royal York Hotel in Toronto on Oct. 27, 28, and 29. Meeting in conjunction with the O.H.A. will be the Canadian Association of Medical Record Librarians and the Women's Hospital Auxiliary Association, Province of Ontario.

The program, arranged by a committee under the chairmanship of J. B. Neilson, M.B.E., M.D., superintendent of the Hamilton General Hospital, Hamilton, Ont., promises yet another interesting and stimulating convention. Sectional meetings receive even more prominence in this year's program. On the suggestion of many 1951 delegates, these meetings will be spaced over several periods instead of being confined to a half-day. The problem clinics, a popular innovation last year, will be held again. Throughout the convention, a selected panel (including not only hospital personnel but also representatives from the Hospitals Division of the Ontario Department of Health and from the Workmen's Compensation Board) will be ready and willing to discuss hospital problems during regular "consulting" hours.

On Monday morning, the convention and exhibits will be officially opened by the Hon. L. O. Breithaupt, LL.D., Lieutenant-Governor of Ontario, and reports will be presented by the president of the O.H.A. and the executive secretary treasurer.

On Monday afternoon, sectional meetings will get under way with the meeting of the nursing administration section. A highlight will be the panel discussion on the place of the nursing assistant in the nursing team of to-morrow. This meeting will be open to all delegates.

On Tuesday morning, four sectional meetings will take place. The trustees' section will be an open session and, while dealing specifically with problems relating to trusteeship, will also feature addresses on topics of general interest such as the nurse shortage, Blue Cross expansion, and government financing of hospitals. The women's hospital auxiliaries sectional meeting will be in the form of a round table discussion and will also include presentation of reports, election of officers, and other business.

At the dietetic section, an important item on the program is to be the report of the committee which has been studying the problem of standardizing curricula for teaching nutrition to student nurses. This committee was inaugurated at last year's meeting and its report will be discussed by a doctor, a nutritionist, and a nurse. The pharmacists' section will include a panel discussion, presentation of reports, and a luncheon, featuring an address by guest speaker, F. N. Hughes, Dean of the Ontario College of Pharmacy.

On Tuesday afternoon, the medical record librarians and the accountants will hold their sectional meetings. The meeting of the former group will include an address on the treatment of cardiac diseases and a problem clinic in the form of a round table discussion. The accounting section is an open meeting and will feature addresses on hospital cost studies, service charges, purchasing, and control of linens. There will also be a demonstration entitled "Monday Morning in the Business Office". Immediately following, a general meeting of the Association will take place with election of officers and other business on the agenda.

On Wednesday, two general sessions will be held. In the morning, a variety of topics will be discussed, including medical practice in the hospital, employer-employee relations, and the hospital as the community health centre. The report of the resolutions committee will also be presented. In the afternoon, the convention will conclude with a round table conference on selected hospital problems.

No convention is complete without special features and these have been arranged to blend into the over-all program. Arranged both on the convention and the convention mezzanine floors will be over 100 attractive exhibits. Several luncheons and breakfasts will be held, with addresses by guest speakers, afternoon tea will be served on Monday with exhibitors as guests of the Association, and a visit will be made to the Toronto Western Hospital, Monday evening. The annual banquet, always an enjoyable highlight of social events, will be held on Tuesday evening, followed by a floor show, and dancing.

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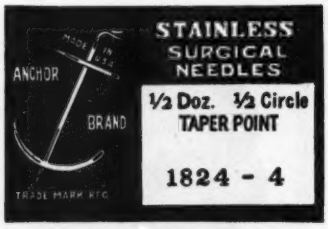

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Routine X-ray Program Invaluable in Hospitals

At the American Hospital Association's convention in September, the association, in conjunction with the National Tuberculosis Association, demonstrated an inexpensive routine x-ray program for patients and employees in a special exhibit.

At one hospital in the U.S.A. in which a similar program has been inaugurated, the astonished administrator reported finding incidence of active pulmonary tuberculosis in the hospital population of almost 40 per 1,000—nearly four times that in the average adult population. And, significantly, more patients were admitted (both medical and surgical) who did *not* know they had tuberculosis than who did.


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Notes on Federal Grants

Construction

Health centres in Kelowna and Vancouver, B.C., have just been awarded federal grants totalling more than $160,000 to help meet their construction costs. In Kelowna, a community health centre is being built on Mill Avenue to serve the South Okanagan Health Unit. It will contain a laboratory, examination room, dental operating rooms and office, public health library, and office space for the medical health officer, public health nurses, and other members of the staff. Construction is scheduled for completion this year and the cost is being shared by the city of Kelowna and the provincial and federal governments. The federal grant will be $14,260.

The health centre in Vancouver will be part of the new provincial health building. The central laboratory of the provincial division of laboratories will be located there. It will contain facilities for the provincial Red Cross blood transfusion depot and out-patient departments for tuberculosis and venereal disease patients. The federal grant will be more than $145,900, with the remainder of the cost being met by the province. Construction is not expected to be completed before 1954.

Professional Training

Five bursaries for special training in aspects of public health have just been awarded in Newfoundland and Prince Edward Island. A woman from St. John's, Nfld., and two residents of Charlottetown, P.E.I., are currently taking a refresher course in syphilis serology at the federal Laboratory of Hygiene, Ottawa. The two other awards go to nurses on the staff of the Provincial Sanatorium, Charlottetown. They will spend three months studying surgical nursing techniques and post-operative care at the Nova Scotia Sanatorium, Kentville, N.S.

Public Health

To aid Manitoba in preventing deaths from poliomyelitis, the federal health department has earmarked funds to buy two extra respirators. These are in addition to respirators already in hospitals throughout the province. One respirator is portable. Both will be used by the provincial Department of Health and Public Welfare to extend care to patients with respiratory paralysis. The federal grant covering the cost of equipment is $3,700.

Research

Research into the value of the recently discovered drug, isonicotinic acid hydrazide, in the treatment of tuberculosis is being carried out at the Mountain Sanatorium, Hamilton, Ont., with the aid of a federal health grant. Research has shown that the tubercle bacillus sometimes develops resistance to streptomycin. The number of cases which develop resistance to streptomycin can be reduced by using another drug, para-amino-salicylic acid (PAS), along with the streptomycin.

The current study at the Mountain Sanatorium will attempt to find out whether or not isonicotinic acid hydrazide has the same effect as PAS and also whether use of streptomycin will reduce the development of strains of tuberculosis resistant to isonicotinic acid hydrazide when these two drugs are given together.

Supplies of isonicotinic acid hydrazide required for the study are being donated by the manufacturers and the federal grant of $2,600 will meet the costs of making monthly laboratory tests. The project is expected to take about a year to complete.

Ontario Government Approves Grants for Six Hospitals

The Ontario government recently approved the allocation of grants, totalling $602,320, to six hospitals. Hospitals receiving the grants are: St. Joseph's, Parry Sound, for 25 nurses' beds, $12,358.68; Hotel Dieu, St. Catharines, for 31 nurses' beds, $31,000; Ongwanada Sanatorium, Kingston, 10 hospital beds, $9,300; St. Joseph's Peterborough, 22 nurses' beds, $22,000; Louise Marshall Hospital, Mount Forest, 12 nurses' beds, $12,000; and South Waterloo Memorial Hospital, Galt, $191,666, for 177 active treatment beds and 44 bassinets.

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Swell Head, and we're justly proud of it. Unlike the magnified head shown in front of the illuminator above—ours is the swell head associated with pride. Notwithstanding innumerable contributions to the mechanics of X-ray, Philips now introduces another signal achievement to a long list of X-ray tube design improvements with a 0.3 mm. focus rotating anode tube.

With this point source, any immobilized part of the anatomy can be greatly enlarged with unexcelled detail. In the above case, the pineal area was enlarged three times to illustrate more clearly the extent and the nature of pineal calcification.

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Plant Bulbs Now—
For Blooms Next Spring

LOVELY flowers can blossom about your hospital next Spring—tulips, daffodils, hyacinths, and crocuses—but only if you plan for them now. You can bring up a series of blooms from late winter to early summer, with the flowers appearing like actors on cue, if the bulbs receive your attention right now.

Snowdrops should receive first consideration, for they need the earliest planting. Plant them between Sept. 1 and Dec. 15, but the earlier the better. For best results, they should be planted near hemlock or yew or any other place where they are not likely to be disturbed and thus will thrive for more than one season.

Clumps of the hardy Dutch crocus, either in a gay yellow or in shades from pure white to deep Bishop's purple, are perfect for rock gardens. These, along with scillas, chionodoxa, grape hyacinths, daffodils, and hyacinths, need early planting. Don't forget the hyacinth because its rich scent will perfume your entire garden. Blooming during the cool days of April, hyacinths often last for several weeks.

Many attractive patterns can be created by arranging flower beds among trees. Tulips can be combined with dogwood, cherries, almond and fruit trees for a delightful scenic effect; while evergreen can be ringed with a deep circle of brilliant Darwins.

Tulip bulbs should never be planted in thin lines or awkard blocks. When in bloom, tulips look best in groups of six, twelve, and more, edging garden walks, surrounding a garden gate, or drifting in the foreground of shrubbery.

Tulips should be planted in October or early November. Early flowering types, such as the Kaufmannianas, will bloom in late March or early April. May-flowering types—Darwins, Breeder, and Cottage tulips, will often last into the early summer. Plant bulbs six inches apart to allow for the spread of foliage and for evenness of blooms, plant all bulbs at the same level.

In actual planting, the first step is to remove the topsoil to a depth of about six inches. If convenient, dig the area a few days in advance of planting to allow the soil to drain well and settle. A two- or three-inch depth is enough for the minor bulbs, such as snowdrops, crocuses, and grape hyacinths.

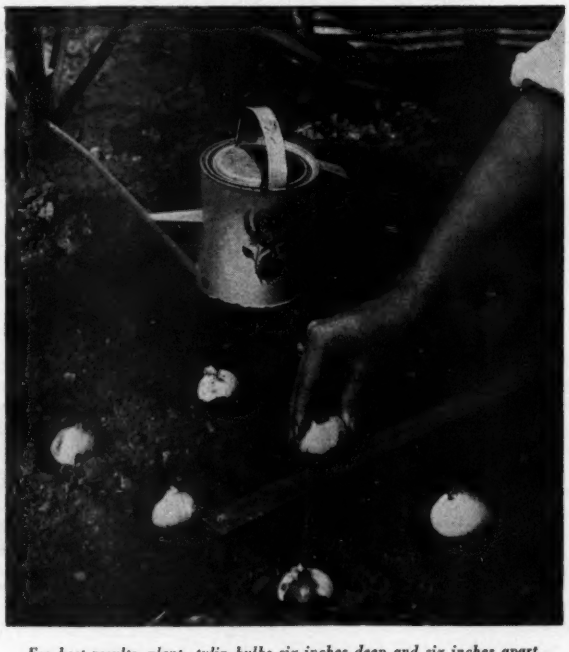
The next step is to insert the bulbs in their respective beds, pointed ends up. Press the base of each bulb firmly against the bottom of the hole in which it rests. Daffodils, tulips, and other narcissus should be placed about the same depth—six inches. The final step, after planting, is to cover the soil with a layer of mulch or leaves or straw just after the surface of the soil is frozen and leave it there until spring—a good, although not absolutely necessary, procedure.

How Did Tulips Get Their Name?

While you are busy planting tulip bulbs this fall, you may be interested in knowing where this flower originated and how it received its name. In the sixteenth century, an Austrian diplomat was travelling through Turkey, bound for Constantinople. He was Ogier Ghiselin de Busbecq, ambassador from Emperor Ferdinand I to Suleiman the Magnificent of the Ottoman Empire. He was amazed and delighted by the profusion of flowers he found growing and later described them as "narcissi and tulipans, as the Turks call them; growing in midwinter, a season unfriendly to flowers". The Turks had a word for the flower—"lalé." However, the ambassador's interpreter probably compared the inverted flower to a turban—"dulband" in Turkish and the ambassador thinking that was the name of the flower, dubbed it "tulipan". This he transliterated into Latin and the novel bloom was christened *genus tulipa*.

Not long after, tulip denoted the latest word for "get-rich-quick" schemes. Europe, especially Holland, was tremendously attracted to the flower and fantastic prices were paid

(Concluded on page 118)



For best results, plant tulip bulbs six inches deep and six inches apart, in loose, porous soil.

Out of the vast clinical experience that has accumulated from the increasing use of Veriloid has come a simplified dosage schedule which rapidly produces relief from the distressing discomfort of hypertension. Within a short period, patients volunteer that they "feel better," even before the blood pressure begins to drop.

Here is the new daily dosage schedule which proves satisfactory for initial therapy in 9 patients out of 10:

1st Dose: After breakfast	2 mg.
2nd Dose: 6 to 8 hours later	2 mg.
3rd Dose: 6 to 8 hours thereafter	2 to 3 mg.

According to this plan, the second dose is taken about two hours after the noon meal, the third dose about two hours after the evening meal.

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This schedule simplifies dosage calculation, is quickly productive of clinical results, minimizes nausea and other side actions. Dosage should be increased by 1 mg. per day every third day until a satisfactory blood pressure drop is achieved. The evening dose is usually 1 or 2 mg. larger than the other two doses of the day. For the average patient, a daily dose of 9 to 15 mg. proves effective and rarely causes side actions.

Veriloid, brand of alkavervir, is a unique alkaloidal fraction of Veratrum viride. It is indicated in the treatment of all grades of essential hypertension and in hypertension of renal origin. Available on prescription at all pharmacies, in 1 and 2 mg. tablets. Order your free copy of the booklet describing Veriloid therapy today.

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Health Care Plans

Ontario Blue Cross Exhibit at the C.N.E.

Ont. Blue Cross Sponsors Blood-Typing Display at the C.N.E.

How many types of blood are there? What do they call them? How can they tell one type from another? What is meant by RH substance? What kinds of blood will mix safely? These were the questions which were answered at the Ontario Hospital Association's Blue Cross display at the Canadian National Exhibition, Toronto, this year.

With the co-operation of the Canadian Society of Laboratory Technologists, the Association sponsored a daily demonstration of blood-typing, supplemented by an informative lecture of about fifteen minutes duration. Sight-seers at the "Ex" found this exhibit extremely interesting.

* * * *

B.C.H.I.S. Announces Changes in Premiums and Hospital Charges

The British Columbia Hospital Insurance Service has announced a reduction in premiums, which became effective on July 1st. The new rates are: single persons, $13.50 semi-annually and $27 annually; two or more persons, $19.50 semi-annually and $39 annually. Where credit is due, the change will be reflected on direct-payment billings for the period from January 1st to June 30th, 1953. In payroll division, adjustment was made in September.

Under the new changes in hospital charges, when a person who is entitled to benefits is admitted to a hospital in British Columbia, that person will be required to pay $1 a day for each day in hospital. This charge applies to every member of a family who is hospitalized on and after August 9th, 1952. The regulation, which effected the change from the previous co-insurance charges, went into effect on August 9th, 1952.

* * * *

Quebec Blue Cross Plan Wins Award In Public Relations Contest

Winners in the national Blue Cross-Blue Shield public relations award contest of 1952 were announced in August at the annual public relations conference of Blue Cross and Blue Shield Plans, held in Chicago, Ill. Two grand awards (for the past year's over-all public relations program) were given.

Six "Class" awards were presented for specific public relations projects carried out during the year—one for each size-classification. The Class II winner (500,000 to 1,000,000 members) was the Quebec Hospital Service Association, the only Canadian Plan thus honoured and the first public relations award ever won by a Canadian Plan. The Quebec Hospital Service Association's program consisted of a series of advertisements in down-to-earth style designed to educate the public in the basic nature of Blue Cross, and a condensed annual report explaining factually the financial operation of the Plan. Both the advertisements and the annual report were published in English and French.

E. Duncan Millican, left, executive director of the Quebec Plan is congratulated by Paul Vaillancourt, member of the executive committee of the Board of Governors of the Quebec Plan and honorary chairman of the public relations committee. See above.

A special message to buyers of

HOSPITAL EQUIPMENT

★ Shown here are a few examples of the wide range of Metal Craft products for hospital use. Look them over as you may be interested in one or more of these items. But the main point of this message is that, whatever your needs, you can always depend on Metal Craft to provide the kind of quality that assures more for the money in extra years of service. A catalogue of the complete line will be mailed to you on request.

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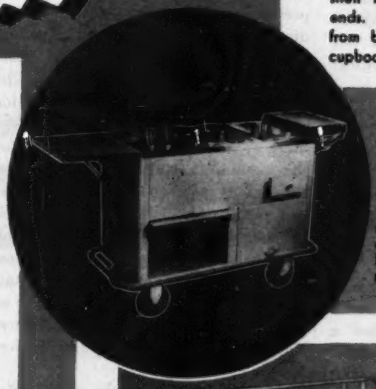

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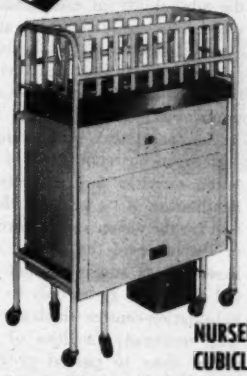

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Nursery Cubicles which have been pioneered by The Metal Craft Co. are offered in several designs, to fit into any shape or size of room. With over a thousand cubicles or units installed, Metal Craft offers a hidden asset of experience.

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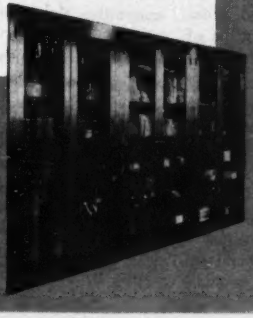
The Metal Craft Bed Series offers the Standard Hospital gatch bed, Trendelenberg Frame, the High-Low bed with fracture frame, Nurses' Residence Beds, all with a selection of bed ends.



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Health Survey Reports

Quebec

A 10-volume report containing scores of recommendations for the future development of health services in Quebec has been completed by a provincial health survey committee and was released recently by the federal health minister. Director-general of the two-year survey was Dr. J. Ernest Sylvestre of the Quebec Department of Health.

To increase the effectiveness of the province's health units, the committee recommends that 24 health districts be set up to co-ordinate the work of several health units and to work out joint programs. Each district medical health officer would be assisted by a senior public health nurse, a tuberculosis clinician, a dental health officer, a nurse trained in mental health, and technicians.

Special sections of the report deal with the health departments of the cities of Montreal and Verdun. The Montreal section notes that "the municipal authority has been very generous in providing for its health services, it has, however, reached a point where it wonders whether it could not obtain some help from senior governments". The section on Verdun suggests the employment of more full-time staff.

The report notes that Quebec lacks sufficient hospital beds and that hospital facilities are not available in all regions of the province. To meet this situation, the committee recommends that the provincial Department of Health continue to favour the opening of hospitals in strategic locations and that financial assistance be given so that one hospital in each region can have a special section staffed and equipped for the treatment of the chronically ill.

To help control cancer, the committee suggests that financial aid be given to all important hospitals to enable them to set up or improve their cancer diagnostic centres and that certain strategically-located hospitals should be assisted in establishing cancer treatment clinics. The scientific direction of cancer control should be left entirely to cancer institutes in each of the province's three universities. The report recommends also that the province assist cancer patients and their families, when their economic situation requires it, by paying costs of hospitalization and treatment and by providing an allowance for the family, especially when the head of the family is the one affected.

More than a dozen recommendations are included concerning the prevention and treatment of mental diseases, including free mobile mental health clinics to serve general practitioners and rural health units; the subsidization of homes to care for persons suffering from senile dementia; the erection of schools for the mentally retarded; increases in the quality and quantity of staff and technical equipment in mental hospitals; support for research in mental diseases; more attention to periodical studies of patients in mental hospitals to ascertain those who are educable or curable; more mental health education; and increased hospital services for epileptics.

The report praises the universities for their leadership in psychiatry and the development of mental health clinics.

The sub-committee on crippled children urges organization of mobile diagnostic clinics to help general practitioners to detect cases which might be helped. It suggests financial aid to the present physiotherapy centres in Montreal and Quebec City; the creation of new centres in strategic locations; and the organization of boarding schools for children who live too far away from these treatment centres to be taken there each day. The committee also urges an increase in the federal grant for work among crippled children.

A section of the report recommends that those parts of Quebec without a doctor be zoned and that financial aid be made available to county councils who would like to subsidize doctors and their wives who will settle in such remote areas. It also suggests small hospital units of eight to ten beds in these areas.

The report suggests that the provincial Department of Health study the question of fluoridating drinking water as a means of preventing tooth decay; urges a more vigorous program of dental health education; suggests organization of a dental faculty at Laval University and of a school for dental hygienists; and recommends consideration of a suggestion to expand full-time dental health services in the health units.

Extensive study was given to the problem of recruiting nurses. Some of the recommendations were: the possibility of shortening the course of training, the creation of schools of nursing affiliated with the hospital schools of the universities, and the organization of more schools for nurses' aides.

Among its general recommendations, the committee suggests that the provincial health department consider the advisability of establishing a service which would supervise and co-ordinate voluntary public health organizations which obtain their funds through public subscriptions and government grants.

The committee's report refers to the "heterogeneous character" of rehabilitation activities and suggests that rehabilitation is "a problem that is too vast for the vision and resources of one or the other of the present organizations". It is suggested that financial aid should be given only to those rehabilitation centres which are affiliated with university faculties of medicine rather than to partial programs inspired by private organizations.

A section of the report deals with the means of increasing the number of people trained in public health and suggests an increase in the federal grant for professional training. The committee also recommends closer co-operation between the provincial departments of health and of education with a view to obtaining better teaching of health in schools.

Manitoba

More than 60 recommendations for expansion and improvement of all phases of public health in Manitoba were disclosed when the province's health survey report was released recently by the Hon. Paul Martin, min-

(Continued on page 110)

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With the Auxiliaries

How May Auxiliaries Best Assist their Hospitals?

(The following is the prize-winning essay, written by Mrs. T. S. G. McMurtry of Vernon, B.C., which won for the women's auxiliary to the Vernon Jubilee Hospital, Vernon, B.C., the Judge and Mrs. J. M. George award for the best essay on "How May Hospital Auxiliaries Best Assist their Hospitals?")

The services a hospital auxiliary may render are many and varied but each is of great value to the efficiency of the institution and to the comfort and pleasure of the patients.

The most valuable aid is financial. Many hospitals would cease to function if auxiliaries did not help with general maintenance. Providing our doctors with necessary specialized equipment to practise modern medicine is important. To improve and beautify the hospital should be part of an auxiliary's work.

Voluntary workers can lower the hospital's expenses by making surgical dressings. Sewing new garments and bed linen, repairing and marking linens can be done efficiently by capable helpers.

Service to individual patients should be part of an auxiliary's work. Transportation to and from hospital or to the out-patient department in the larger centres, means much to the impoverished ill. Letter writing for incapable patients often would bring peace of mind. Providing clothing for the needy person or infant, on discharge, could be another valuable contribution. Those attending the out-patient department could be served a refreshing drink.

Bringing pleasure through mental and physical stimuli often not only brings happiness but speeds the recovery of the sick. Voluntary libraries, containing books, periodicals, and newspapers, taken to the patients, provide enjoyment through the literature and the warm friendly spirit of the worker. Telling stories to children and reading to those who desire it can bring pleasure. Providing occupational therapy for idle hands can be carried out even on a small scale, where such service is not provided. Patients able to sit in wheelchairs would sometimes benefit from an outing in the sunshine if responsible women were available. Auxiliaries can do much to make festive days less lonely by providing gay decorations for trays, miniature Christmas trees, and individual gifts for children or those who would otherwise be forgotten. Flowers in season might be arranged and distributed throughout the hospital to add beauty.

Women in hospital auxiliaries could stimulate interest in the nursing profession and help assure our hospitals of well trained staffs in the future. As most members are mothers, many being inactive nurses or wives of doctors, they could do much through praising to young women the worthiness and satisfaction derived from the care of the sick. Bursaries offered by auxiliaries give opportunity for advanced education in nursing. By making the nurses' living quarters attractive and comfortable they help to bring contentment among the staff.

The auxiliary is the important link between the hospital and the public. Members can interpret the needs and problems of the hospital to the public and bring a better understanding. Through their enthusiam in money-raising projects they can interest more women in helping their hospital.

The following are the best proved ways of raising funds for auxiliary work: catering, bazaars, fashion shows, superfluity shop, tag days, raffles, bridge parties, gift shop in hospital, rummage sales, mobile shop, dances, sale of homecooking, sale of flowers and teas.

* * * *

Auxiliary Organized in 1948 Has Notable Record

The auxiliary to the Winchester and District Memorial Hospital, Winchester, Ont., was organized in the fall of 1948, simultaneously with the opening of the hospital. During the first year of operation, the surrounding districts organized their own units to work with the parent body. At that time, there were 11 units, with a total membership of 832. During the succeeding three years, the membership has increased slightly and, at present, there are 16 active units.

Between $2,500 to $3,000 has been raised each year by the auxiliary. Some of the larger projects undertaken have been the installation of a water softener at a cost of $1,938; an electric call system, $1,000; mixmaster, $400; meat and vegetable slicer, $367; suction and pressure machine, $490; laboratory equipment, $1,000; furniture for the nurses' dining room, $250; as well as many smaller expenditures for linens, cupboards, kitchen equipment, et cetera.

The parent auxiliary, working through the smaller units, is responsible for the annual "Donation Day" when goods, valued at more than $2,000, are received at the hospital.

Money for the various projects is raised through teas, bazaars, food sales, concerts, and other community activities. Members visit the hospital regularly to do the necessary sewing and mending. The library committee of the auxiliary cares for the library and distributes books and magazines in the wards each week.

* * * *

Much Valuable Equipment Supplied to Hospital at Campbellton, N.B.

In the past few years, the members of the ladies' aid to the Soldiers' Memorial Hospital, Campbellton, N.B., have supplied their hospital with many valuable pieces of equipment. The auxiliary has raised funds for the purchase of a new operating room table, x-ray and laboratory equipment, an explosion proof lamp for the case room and a fracture table. In addition, they have had several rooms renovated and refurnished, as well as supplying the hospital with chairs, drapes, blankets, and floor coverings. Christmas treats for the patients and student nurses are also donated by the ladies.

Perseverance is more prevailing than violence; and many things which cannot be overcome when they are together, yield themselves up when taken little by little.—*Plutarch*

ANOTHER Lawson Associates Success . . .

. . . Gives Charlottetown Hospital $347,000 In a Campaign That Sought Only $300,000 *For Debt Reduction, Not New Building!*

In one of the most unique campaigns in the history of hospital fund raising, Lawson Associates, Inc. planned and directed a public relations and fund-raising appeal for Charlottetown Hospital, Charlottetown, P.E.I., Canada, for funds not for new facilities but to pay off a debt contracted years ago for constructing existing facilities.

It is axiomatic that a fund-raising campaign for debt reduction on existing hospital facilities is the most difficult kind of appeal to the public for funds.

That Lawson Associates was able to plan and direct this campaign . . . and obtain an oversubscription . . . is final evidence of the quality of this firm's hospital public relations and fund-raising services.

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Notes About People

(Concluded from page 16)

in 1931. He interned at St. Michael's Hospital, Toronto, and then took post-graduate courses in internal medicine in London, England.

After practising in Toronto for a few years, Dr. Cragg joined the Tuberculosis division of the Ontario Department of Health in 1936. Two years later he became superintendent of the St. Lawrence Sanatorium.

Dr. Cragg was a Fellow of the American College of Physicians and Surgeons. He played an active part in many community organizations, including the United Counties Medical Society, of which he was past president.

* * * *

Gertrude Bennett Reg.N.

Miss Gertrude Bennett, formerly superintendent of nurses at the Ottawa Civic Hospital, Ottawa, died on August 31st, at the age of 72. Born in Toronto, Ont., Miss Bennett later moved with her parents to Ottawa. Shortly after graduating from the Montreal General Hospital's School for Nurses in 1902, she was appointed matron of the Brockville General Hospital, Brockville, Ont., remaining there until 1914. After five years of private duty nursing in Ottawa, Miss Bennett became "lady superintendent" of the Royal Ottawa Sanatorium, a post she held until 1924 when she was appointed superintendent of nurses at the Ottawa Civic Hospital. Miss Bennett held the latter position until she retired in October, 1946.

During her long and distinguished nursing career, Miss Bennett was a member of the Dominion Board of the Victorian Order of Nurses; on the board of the Ontario Registered Nurses' Association; and a former chairman of the Council of Nurse Education in Ontario. She was also an active member of the Imperial Order of the Daughters of the Empire.

* * * *

New Superintendent For Hospital at Truro, N.S.

Mrs. Sarah MacCarthy has been appointed superintendent of the Colchester County Hospital, Truro, N.S. She succeeds Mrs. Grace Bethel.

Mrs. MacCarthy has been on the staff of the hospital for six years and has been assistant superintendent for the past three. She took over her new duties on September 1st.

Cornerstone Laid by Lord Elgin

An impressive and long-to-be-remembered ceremony was witnessed by the people of St. Thomas, Ontario, and Elgin county, when, on August 5th, the Earl of Elgin and Kincardine laid the cornerstone of the new $3,500,000, 330-bed Elgin and St. Thomas General Hospital. Lady Elgin, who accompanied her husband, was among the honoured guests. The Hon. Paul Martin, minister of National Health and Welfare, introduced Lord Elgin, and the Hon. Dr. MacKinnon Phillips, minister of health for Ontario, extended greetings from the province. The ceremony, which took place at the incompleted main entrance of the hospital, was the highlight of a week-long program to celebrate the centennial anniversary of the city and the county.

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Flavour—
17 out of 22 people called the correct flavour on a blind test by taste.

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We served from powder to finished dessert in 15 minutes.

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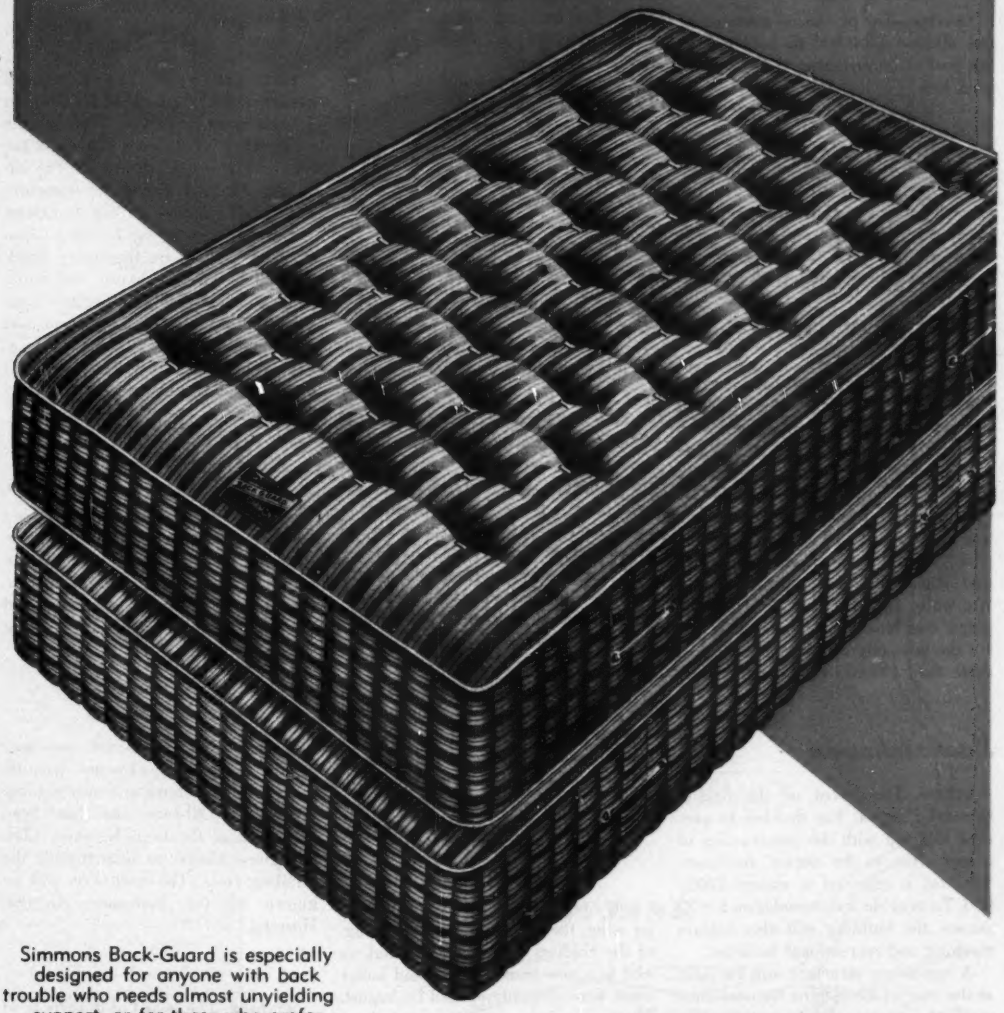

Simmons Back-Guard is especially designed for anyone with back trouble who needs almost unyielding support, or for those who prefer a good firm mattress. The matching box spring provides an additional platform to the Back-Guard mattress. Available in all standard sizes—Simmons precision "auto-lock" spring unit—all-felt upholstering—decorative metal handles for easy turning..

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Provincial Notes

British Columbia

CRESTON. The provincial government has allotted $300,000 to help toward the cost of constructing a 30-bed hospital here.

• • • •

TRAIL. The Trail-Tadanac hospital board has signed a contract for the construction of a 150-bed hospital. It is expected that construction work will begin shortly. The total cost of the building will be approximately $2,128,000.

• • • •

WHITE ROCK. It is hoped that construction will begin this fall on the $150,000 hospital to be built here. The design under consideration calls for a 28-bed nursing unit and a seven-bed maternity wing. Provision has been made for two operating rooms, an x-ray room, and a morgue. To be built in the shape of a "T", the hospital will be a frame and stucco building with laminated fire walls. In September 1951 a campaign was launched to raise $100,000 for the hospital; of this sum a total of more than $95,000 has been received.

Saskatchewan

REGINA. The board of the Regina General Hospital has decided to proceed this fall with the construction of a new wing to the nurses' residence. The cost is expected to exceed $200,000. To provide accommodation for 32 nurses, the building will also contain teaching and recreational facilities.

A one-storey structure will be built at the rear of the Regina General Hospital, also, to provide new quarters for housing the rabbits and guinea pigs used in the hospital's laboratory. The building will have a full foundation, cement floor, stuccoed cindercrete walls, and a sloping lean-to roof. It will be 90 feet long and 20 feet wide, divided into three separate compartments; one for the animals, the middle one for storage, and the third for garbage. The building will cost approximately $12,000.

Ontario

KITCHENER. The provincial government has agreed to pay half the $199,200 renovation cost of converting the old Kitchener-Waterloo Hospital into a unit for the chronically ill. Some additional funds will be provided by the province for the laboratory, which has been installed on the third floor of the long-term unit.

• • • •

LONDON. Work has begun on the $900,000, two-wing addition to St. Joseph's Hospital. The east wing of the addition will extend from the present east wing toward Wellington street and will provide space for an additional 100 beds. This five-storey unit will house the out-patient department, obstetrical ward, 32 beds for children, beds for mild psychiatric cases, as well as quarters for sister supervisors.

The second wing will extend south from the present Grosvenor street entrance and will provide space for 60 to 70 surgical beds, in addition to new administration offices. The additions will increase the hospital's capacity to approximately 447 beds.

• • • •

ORILLIA. The new $450,000 maternity wing, the Princess Elizabeth Wing, of the Soldiers' Memorial Hospital, as well as a new laundry room and boiler plant were officially opened in August. The wing is presently equipped to accommodate 32 patients with an equal number of nursery cubicles, but there is sufficient space to increase this number by half. New classrooms and demonstration facilities for the nursing school are also located in the wing.

OTTAWA. The new Ontario Cancer Foundation Clinic in the Ottawa Civic Hospital was opened in September. The Ontario Cancer Society recently granted the hospital $50,000 to aid in the construction costs of the addition. Modern therapeutic and other equipment, estimated to cost about $60,000, has been installed with funds provided by the federal and provincial governments.

• • • •

SAULT STE. MARIE. The city council has sanctioned the issue of $600,000 in debentures as its part in financing the construction of a new addition to the Plummer Memorial Hospital. The addition will be a five-storey structure and will be joined to the southwest corner of the existing building. Also attached to the main five-storey building will be an "L"-shaped, one-storey wing, which will contain the new laundry facilities, a staff dining room, and accommodation for 20 long-term patients. The wing is expected to be completed about 18 months after construction begins.

• • • •

STRATFORD. About 60 non-union employees of the Stratford General Hospital have received a $5.00-a-month wage increase, retroactive to July 1st. The increase was approved by the hospital's board at a recent meeting.

• • • •

WALLACEBURG. Plans are underway for the construction of a new hospital to serve Wallaceburg and surrounding district. A 10-acre site has been donated and the local Kinsmen Club has given $1,000 to help toward the building costs. The institution will be known as the Sydenham General Hospital.

• • • •

WINDSOR. The board of governors of the Metropolitan General Hospital have approved the adoption of a nurses' training program similar to that in operation at the Toronto Western Hospital. The demonstration school, which has operated at the Metropolitan Gen-

(Concluded on page 116)

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Abbott A-C-D Blood Containers—A-C-D Solution, U.S.P. (N.I.H. Formula 9), in the familiar conical-shaped Abbott intravenous bottles, 500- and 250-cc. sizes. Blood is drawn (closed technique) directly into container by gravity. Also available with Donapak 24 and 48, with or without disposable needles. Designed for exclusive use with Abbott I.V. Equipment.

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ADMINISTERING BLOOD and or SOLUTIONS

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VENOPAK®—Abbott's sterile, disposable, venoclysis unit for the administration of all intravenous solutions. Converts readily to a blood recipient set with a special, disposable blood filter. For use exclusively with Abbott conical-shaped bottles.

(Series Hookup)

Secondary Recipient Set—A unique, disposable unit with a built-in, flexible drip chamber and filter. Designed to plug into any Universal blood bottle and to connect with Abbott's VENOPAK dispensing unit. Allows changeover from saline to blood in a matter of moments, without removing needle from vein.

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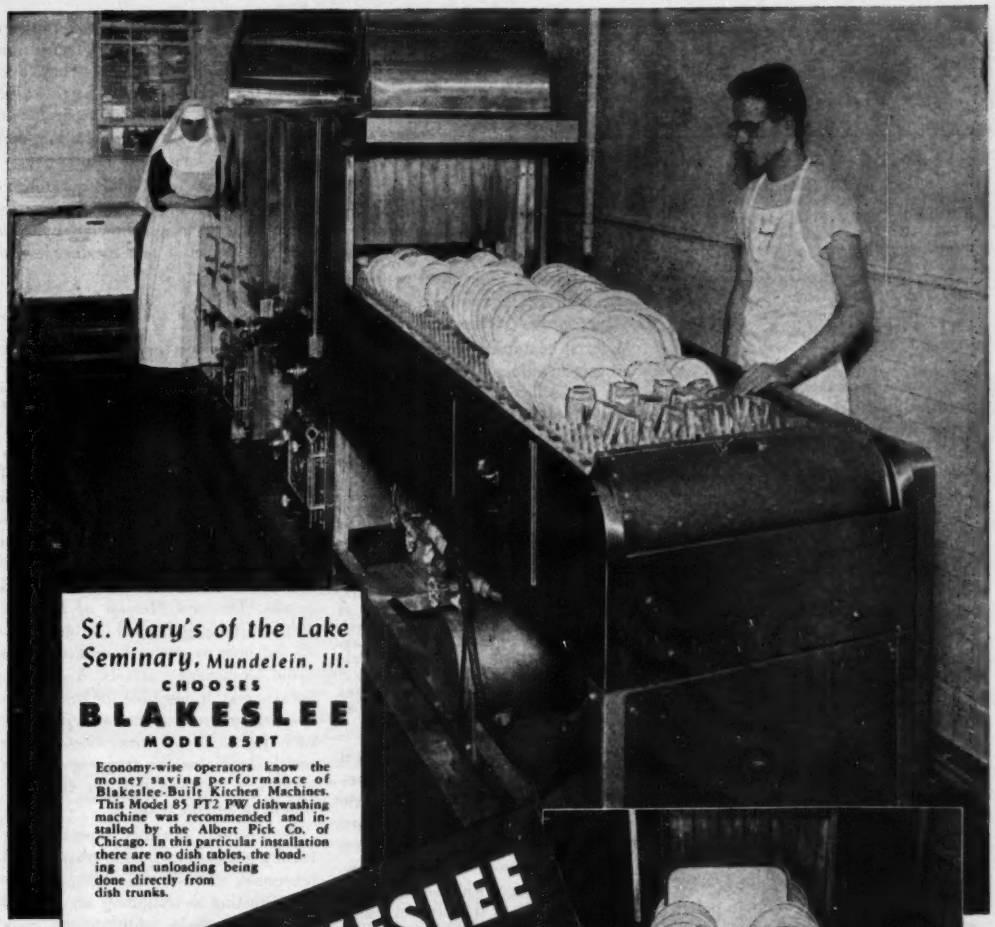

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Note the continuous travelling conveyor that eliminates the handling of dish racks, cup racks and bowl racks. The all-nylon automatic conveyor pictured at right cannot scratch or mar the finest china. Note how the conveyor accommodates the dishes, trays, silverware and glassware.

Write for full facts on particular Blakeslee equipment to fit any specific kitchen need.

Book Reviews

PREVENTIVE MEDICINE AND PUBLIC HEALTH (Second Edition). By Wilson G. Smillie, A.B., M.D., D.P.H., Sc.D. (Hon.), Professor of Public Health and Preventive Medicine, Cornell University Medical College, New York, N.Y. Pp. 603. Illustrated by charts. Price, $7.50. Published by The MacMillan Company, New York. Canadian agents, The MacMillan Company of Canada Ltd., Toronto.

Dr. Smillie, in this second edition of *Preventive Medicine and Public Health*, presents his readers with a thoroughly revised text in which he has critically re-examined every aspect of preventive medicine so as to assure the elimination of out-moded procedures.

Since the first edition, published in 1946, there have been many changes and striking advances in the fields of public health and preventive medicine. The author outlines the new trends in these fields. The rapid evolvement of antibiotics and the use of more effective insecticides are but two of the many important developments.

Social structures and social concepts have changed also. During and since World War II, children have become more numerous and this text places more emphasis on child health protection. Accidents are considered an important cause of illness and death, with the chief cause of death in youth being through violence. For this reason a new chapter on accidents has been placed in the section on child health protection. Another new chapter, prepared by Dr. Franklin Foote, has been added on "Conservation of Vision" and appears in this section also.

Major changes in the revised edition are concerned with the increasingly important and very broad field of promotion of health and prolongation of life among the adult population. Material on this subject has been completely re-arranged and brought up to date.

Environmental sanitation has been given much less emphasis. Dr. Smillie states that "environment does have a profound influence on health and disease but the major environmental hazards have been solved, for the most part, or will be solved in the near future." The author has placed more stress on community planning for health promotion. Under this section, Dr. Smillie deals with rehabilitation, plans for adequate care of the aged, and development of medical care programs, with special emphasis on voluntary prepayment sickness insurance.

Material contained in this book will be of special value to those directly engaged in the fields of preventive medicine and public health. In addition, it will serve as an informative text for all those connected, in any way, with the promotion of health.

* * * *

CARDIOGRAPHIC TECHNIQUE. By S. L. Barron, Member of the Royal Institute of Great Britain, and A. Schott, M.D., M.R.C.S., medical officer in charge of Cardiographic Department, Queen Mary's Hospital for East End, London, Eng. Pp. 156. Illustrated. Price, $4.25. Published by William Heinemann, Medical Books Ltd., London, Eng. Canadian agents, British Book Services Ltd., Toronto.

Here is a manual for cardiological technicians, which defines the important duties and responsibilities of technicians in cardiography and in particular electrocardiography. Further, it provides the more extensive knowledge of the subject which is indispensable to technicians if their work is to be of the high standard that the physician requires.

Professor Crighton Bramwell, professor of cardiology, University of Manchester, and physician, Royal Infirmary, Manchester, in the foreword, recalls that the physician of 30 years ago recorded his own electrocardiograms and that his technician (if he had one) was responsible "merely for maintenance of the instrument and for processing the records". But nowadays, "the cardiologist is concerned chiefly with interpretation" and depends on his technician "not merely to produce a high-class record suitable, if necessary, for publication but also to master the fundamental physical principles of both electrocardiography and phonocardiography. He must recognize artefacts and be able to remedy the simpler instrumental defects responsible for their production."

The authors describe the foundations, both physical and biological, on which cardiography rests. They also detail the technique which ought to be employed for obtaining accurate records, including the recognition and elimination of common faults.

This manual is of value, not only to the technician, but also to the physician, who is his own technician, by helping him to detect and localize instrumental faults.

* * * *

MANUAL OF HOSPITAL HOUSEKEEPING. Published by the American Hospital Association, 18 East Division St., Chicago, Ill. Pp. 110, laminated paper cover. Price, $1.50.

Training new, inexperienced housekeeping personnel in the techniques of their jobs has often posed a problem for institutional housekeepers. Too often lack of time, coupled with an "anyone ought to know how to dust" feeling, have not produced very good results. The new *Manual of Hospital Housekeeping*, published by the A.H.A. should help executive housekeepers to avoid haphazard methods. A comprehensive text, it describes the best housekeeping procedures, explains just how each job is to be done, cites factors which determine the frequency of the operation, and tells how the employee should be taught to do it.

In a section designed especially for maids, porters, and other department personnel, all basic cleaning operations from dusting to scrubbing are defined and described. In addition, the book tells how to perform specific cleaning jobs, such as washing windows, maintaining terrazzo tile, soft-wood floors, carpeting and metal furniture, all of which should be helpful not only in training but also in establishing standard procedures. In the section written especially for the housekeeper herself, responsibilities of the department, relation of housekeeping to patient care and to hygiene, fire and safety programs, a personnel training program, and records, are discussed. A chapter on interior decoration and a list of reference material completes the housekeeping picture.

This manual was developed after a great deal of research. The Association's committee on hospital housekeeping, explored housekeeping practices in hotels, schools, and industry,

(Concluded on page 106)

For unsurpassed quality . . .

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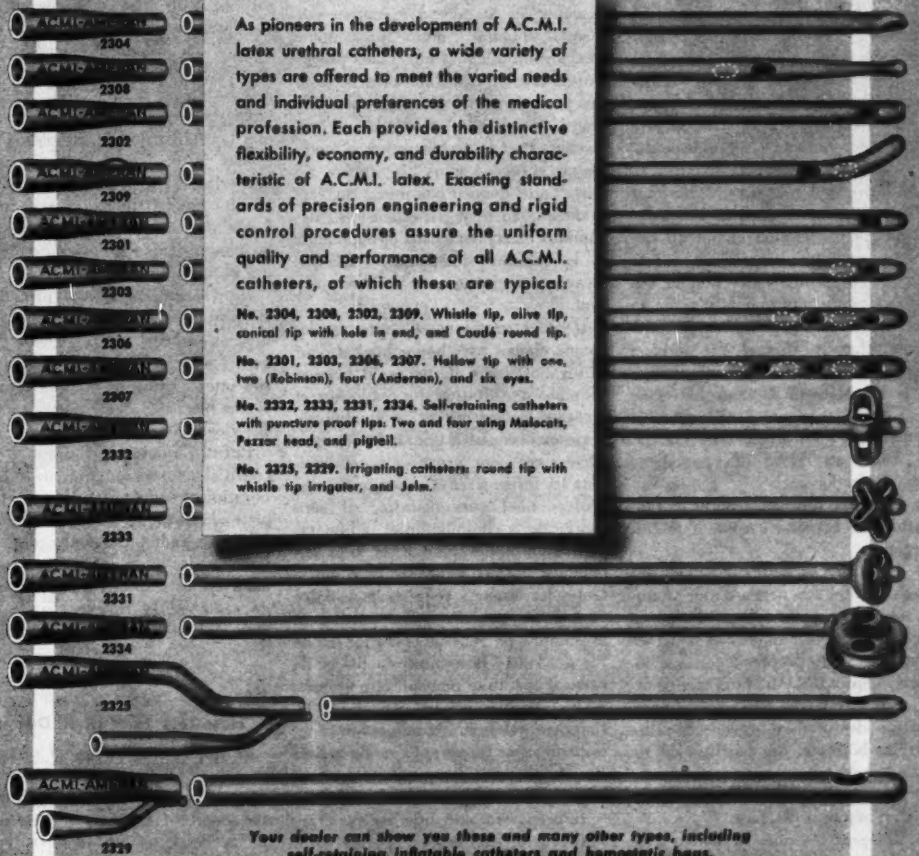

As pioneers in the development of A.C.M.I. latex urethral catheters, a wide variety of types are offered to meet the varied needs and individual preferences of the medical profession. Each provides the distinctive flexibility, economy, and durability characteristic of A.C.M.I. latex. Exacting standards of precision engineering and rigid control procedures assure the uniform quality and performance of all A.C.M.I. catheters, of which these are typical:

No. 2304, 2308, 2302, 2309. Whistle tip, olive tip, conical tip with hole in end, and Coudé round tip.

No. 2301, 2303, 2306, 2307. Hollow tip with one, two (Robinson), four (Anderson), and six eyes.

No. 2332, 2333, 2331, 2334. Self-retaining catheters with puncture proof tips: Two and four wing Malecots, Pezzer head, and pigtail.

No. 2325, 2329. Irrigating catheters: round tip with whistle tip irrigator, and Jelm.

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Hôpitaux et Défence Civile

(Suite de la page 36)

docteurs Ad. Groulx, directeur du service de santé de la Défense Civile et le docteur R. Lamquin, officier médical de la Défense Civile, qui agit comme secrétaire du comité. A ces membres seront ajoutés deux représentants de la "Conférence catholique des hôpitaux de Montréal".

Responsabilitiés du "Comité des hôpitaux."

Dans l'organisation nationale de la Défense Civile, à Ottawa, on a formé et réuni des "groupes d'étude, dont l'un concerne les services des victimes", chargés de recommander les mesures à prendre en cas de désastre. Ce comité insiste sur la nécessité (je cite) "d'une uniformité d'action à travers le pays afin d'eviter des lacunes dans le programme de soutien. C'est indispensable au Canada . . ."

Un sous-comité du service hospitalier a été formé pour faciliter l'élaboration des plans détaillés et obtenir des résultats uniformes.

Les responsabilités du "Comité des hôpitaux" dans une région, d'après les directives émises par le Comité national et selon le *Manuel des services sanitaires de la Défense Civile*, publie par le Ministère de la santé nationale et du bien-être social à Ottawa, sont résumées dans les termes suivants:

1. Faire un relevé des ressources hospitalières locales;

2. Elaborer un plan général d'organisation des hôpitaux en vue d'un état d'urgence;

3. Classifier les hôpitaux actuels des zones-cibles et des zones d'aide mutuelle et dresser des plans d'urgence détaillés pour ces hôpitaux et pour des immeubles jugés propres à servir d'hôpitaux improvisés ou d'urgence dans ces mêmes zones et collaborer à l'élaboration des plans d'urgence détaillés pour les hôpitaux des localités de réception et de renfort mobile—qui sont situés en des points convenables pour servir d'hôpitaux de base.

4. Intégrer les zones d'hôpital avec les postes mobiles de premiers soins et les services auxiliaires;

5. Assurer leur coordination et leur relation avec les hôpitaux régionaux avec la collaboration du comité provincial et le comité national de la Défense Civile et rattacher, en accord avec les données géographiques, chaque hôpital métropolitain à un hôpital régional vers lequel sera dirigée l'évacuation prévue des malades et des blessés;

6. Etablir des contacts avec endroits éloignés pouvant envoyer de l'aide d'urgence et préparer des plans à cet effet; et transmettre les requêtes des hôpitaux aux autorités compétentes.

En plus de ces responsabilités d'un caractère général, le "Comité des hôpitaux" agit comme agent de contrôle et de surveillance; il aura pour fonctions de faire le contact avec le surintendant et le directeur médical de chaque hôpital et expliquer les plans établis d'organisation en regard d'un état d'urgence.

Ce comité a pour mission, en plus, de contrôler la mise à exécution par chaque hôpital d'un programme d'expansion adéquat aux plans prévus d'organization et des mesures nécessaires pour permettre l'hospitalisation de toutes les victimes dont l'état le nécessiterait, et l'administration à toutes les victimes des soins hospitaliers requis. Cette donnée comprend un programme adéquat d'expansion des hôpitaux existants, locaux et régionaux, et la création d'hôpitaux d'urgence, locaux et régionaux, en nombre suffisant.

Il devra examiner et approuver les locaux choisis par chaque hôpital pour servir d'hôpitaux d'urgence; il dressera les plans d'utilisation des ces locaux et établira le nombre et la qualité du personnel requis; il prenda les mesures nécessaires pour procurer à ces hôpitaux les infirmières et le personnel non professionnel surnuméraire; il sera chargé de la compilation et indiquera, sur carte topographique, la liste des hôpitaux locaux existants, y compris toutes les données requises pour faire face à un état d'urgence concernant le nombre de salles d'opération et de lits existants; le nombre de lits et de salles d'opération pouvant être ajoutés, et les endroits prévus pour l'évacuation de ces derniers; compilation et report sur carte topographique de la liste des hôpitaux d'urgence et de leur capacité.

Il préparera une liste du matériel, fournitures, équipement requis pour chaque hôpital existant et chaque hôpital d'urgence et la transmettra au comité central des hôpitaux ou à la branche des approvisionnements de la section de la santé.

Il verra au groupement par équipes du personnel hospitalier professionnel et veillera au recrutement et à l'instruction du personnel auxiliaire et à l'étiquetage des lits des patients selon la méthode proposée par le docteur Campbell Gardner, dans sa causerie présentée au Montréal Medico Chirurgical Society all-day Session au Queen Mary Veterans' Hospital, May, 1951.

Conclusions

Dans l'étude du problème des soins médicaux et de l'organisation des services hospitaliers en cas d'urgence, il faut tenir compte des "Principes de base" qui président à l'organisation même du service de santé de la Défense Civile.

Le premier principe est qu'aucune ville ne peut se suffire à elle-même en cas d'urgence; cette situation s'applique de façon particulièrement grave en ce qui a trait aux facilités médicales et sanitaires.

Le deuxième principe directeur est que l'organisation du service de santé doit se faire selon les prescriptions de l'autorité fédérale afin d'en arriver à l'uniformité par tout le pays et assurer l'aide mutuelle efficace des zones environnantes et une aide mobile effective des zones éloignées.

Le troisième et dernier principe est l'importance de la coordination de tous les services de la Défense Civile avec le service de santé, surtout dans son intérêt direct au soin des malades et des blessés et à la protection même des vies humaines.

Enfin, j'ajouterai un autre principe essentiel au succès, celui de la collaboration et coopération sincère et complète de tous les groupes intéressés, hôpitaux, administrateurs des hôpitaux, médecins et infirmières et leurs associations respectives avec le Service de santé de la Défense Civile de la zone-cible et le Comité des hôpitaux.

* * * *

Résumé

Hospitals and Civil Defence

Hospitals are the "point of convergence" of all the civil defence services responsible for the care of victims in the event of a disaster. In studying the general set up of civil defence health services in a target area, we may notice that the hospitals constitute a very important section in the branch of medical services, together with ambulance services, mobile first aid stations, et cetera.

The organization of civil defence health services for the Montreal metropolitan area includes four main

(Continued on page 82)

NEW

Davis & Geck's Spiral Wound Surgical Gut on a cylindrical reel!

Saves time makes easier ties

For surer hand ties

When the surgeon makes a series of hand ties, D & G Spiral Wound Surgical Gut USP unreels in his hand, free from kinks, with all its tensile strength preserved.

The gut should be gently pulled out straight immediately after removal from the tube.

Surgeons welcome a new convenience—D & G Spiral Wound Surgical Gut. It is wound on a cylindrical reel—comes *ready for immediate use* in ligation and suturing. Spiral winding preserves all the original strength. None is lost through kinks or bends.

Nurses, too, save time with Spiral Wound Gut. No more unwinding from an old style flat reel and rewinding onto a rubber tube, glass rod or spindle.

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Hospitals and Civil Defence

(Concluded from page 80)

branches which are: public health, medical services, supply, and special services.

Existing and Auxiliary Hospitals

The problem that faces the hospital is conditioned: (a) on one hand, by the ravages of modern weapons, and by the extent and concentration of disaster brought on by a single atomic explosion; and (b) on the other hand, by the fact that the hospitals are insufficient in number and are concentrated in small zones in the very heart of the target city and thus highly exposed to destruction.

The essential measures to be taken are:

1. survey of existing facilities;
2. adequate organization of hospitals for disasters;
3. plan for expansion of actual hospital facilities and creation of improvised hospitals;
4. co-operation between hospitals and other civil defence services;
5. co-ordination of civil defence hospital planning in an area with that in nearby regions.

For civil defence purposes, hospitals in a region and its vicinity are divided into three types: general or specialized existing hospitals; improvised hospitals; and hospitals in surrounding areas.

Hospitals' Responsibilities

Each type of hospital is entrusted with special responsibilities. For existing hospitals, general or special, in target areas, these responsibilities are:

Apply locally established general plans of organization for disaster;

Form a civil defence committee in the hospital and appoint a civil defence officer for personnel;

Establish a plan of emergency organization based on certain essential data provided by the Federal Civil Defence Health Planning Group.

Give adequate hospital care to the sick and wounded;

Re-organize services in the light of new needs—increase personnel and allocate duties, re-organize nursing staff;

Re-orientate medical services;

Organize food services, business offices, and other essential services.

Improvised Hospitals

With the aid of a hospital committee, existing hospitals in target areas should plan in advance to set up improvised hospitals in suitable buildings in the vicinity, *e.g.*, schools and hotels. In a disaster, the existing hospitals must shoulder the responsibility of converting pre-designated buildings into improvised hospitals, and assure efficient functioning of same. Improvised hospitals may be used as casualty stations. Most cases of burns, victims of radiation, and cases of ordinary fracture, should be handled there.

Regional hospitals, located in nearby regions, will receive the sick and casualties evacuated from improvised or existing hospitals, and mobile first aid stations. It is the responsibility of the officers of the local civil defence organization to arrange with provincial civil defence authorities for transportation and reception of the victims.

Local Hospital Committee

This committee should include representatives of the local hospital council, of the medical societies, and of the local department of health. In Ottawa, a sub-committee of hospitals has been created to establish plans for hospitals in order to ensure uniformity of organization throughout the provinces.

The local hospital committee is responsible for: surveying local hospital facilities; elaborating a general plan of organization for hospitals and classifying existing hospitals in the target zone and in the mutual aid zone, as well as co-ordinating them with nearby hospitals.

This committee will also act as control and liaison agent. It will supervize the execution of the program of expansion and of all related pre-disaster measures. It will contact the medical authorities in each hospital, and examine and approve the selection of improvised hospitals, their number, and elaborate plans. It will help in securing required supernumerary personnel, additional supplies, et cetera.

In conclusion, there are three basic principles, necessary in the organization of the civil defence health service.

1. No target city is in any respect self-sufficient in an emergency.

2. The health service organization has to be designed in accordance with the official prescriptions of the federal authority in order to achieve nation-wide uniformity and secure efficient mutual help.

3. There is an imperative necessity to co-ordinate all the various services of civil defence with the health service.

Another requirement essential for success is the full co-operation of all interested groups, hospitals, administrators, physicians, surgeons, and nurses, with the civil defence health service. ●

Alberta Tuberculosis Association Report of Mobile Chest X-Ray Units

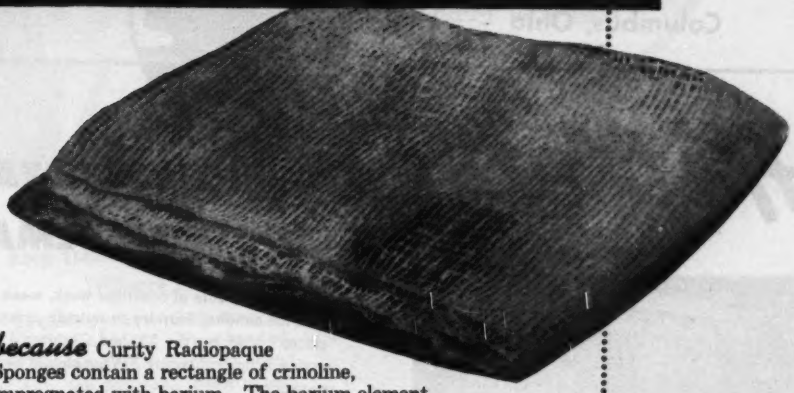
A report issued recently by the Alberta Tuberculosis Association gives a statistical summary of persons x-rayed by the Christmas Seal mobile chest x-ray units which are operated jointly by the tuberculosis division, Alberta Tuberculosis Association. The summary is as follows:

From March 1 to August 31, 1952	Films Interpreted	Probable TB Active	Probable TB Inactive	Other Abnormalities
Edmonton	72,765	32	481	1,636
Fairview	1,598	0	10	28
Hines Creek	885	3	7	16
Worsley	397	0	0	2
Berwyn	677	0	5	5
X-rayed prior to March 1, 1952	847,691	993	7,361	24,368
Totals to date	924,013	1,028	7,864	26,055
Total Abnormalities	32,722			

It should be noted that this report covers only the six months from March 1 to August 31. In the large-scale Edmonton survey, prior to March 1st, there were 38,752 persons who had received free chest x-rays, so that totals for the entire Edmonton survey are as follows:

	Films Interpreted	Probable T.B. Active	Probable T.B. Inactive	Other Abnormalities
Edmonton Survey	111,517	53	669	2,570
At University of Alberta	887	0	6	30

NO OTHER INSERT IS AS OPAQUE TO X-RAY



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At far left, two new end-loading "Shell-Less" washers to supplement a previously installed 44 x 54 "Shell-Less", which was elevated for faster unloading. At right, a new 40-inch open-top extractor.

Bottleneck in finishing linen was broken by the addition of a 4-roll, 110-inch Hoffman flatwork ironer, a 42 x 60 "Balanced Suction" tumbler and (not shown) a 36 x 30 "Ucon" Tumbler.

A heavy schedule of overtime work, week after week — repeated need for sending laundry to outside processors — these were the "prices" paid by the 200-bed Children's Hospital for increasing service to its community. "What should be done about our laundry operation?"

A Hoffman laundry survey confirmed the fact that occupancy close to 100% (through the admission of adult polio cases) and work from a new nurses' home had established a basic laundry load greater than the existing equipment could handle or stay "caught up" with.

At the request of the Hospital's officials, two sets of plans for modernized laundries were prepared by Hoffman laundry engineers. One, for a new laundry in the existing floor space; the other, for an enlarged laundry in a building extension. Either arrangement provided a laundry operation matched to the needs. However, recalling the painful experiences of their soon-too-small, old laundry, Children's Hospital decided on the building addition. Installation of Hoffman laundry equipment has resulted in a reduction in the laundry work week and linen supply balanced to today's needs — capable of expansion to tomorrow's growth.

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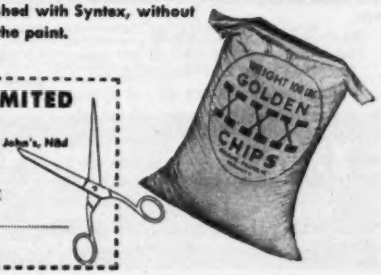

B.C. Hospital Insurance

(Continued from page 38)

insurance—in some form—is necessary, for several obvious reasons; but a political battle has recently been fought in British Columbia with co-insurance as a major bone of contention. The results, at this writing, are not clear*. The advent of co-insurance was an unfortunate factor in bringing hospitals into the political arena but it would appear that this is no more than a temporary situation.

From the public point of view, chronic care is the most contentious factor in the insurance plan. The Hospital Insurance Service pays the cost of care as long as the patient requires the in-patient services of an active treatment hospital but terminates coverage when it is determined that the patient could be adequately cared for elsewhere. Early in 1952 a Medical Review Board was appointed to review questioned cases. Three of the five members of the Board are selected by the B.C. College of Physicians and Surgeons. Neither the individual patient nor his family can understand that benefits cease when the acute stage of the disease develops into a chronic care problem. British Columbia is not alone in this. All of us are faced with the need for further action in our chronic care programs, but it must be understood that the British Columbia Hospital Insurance Service is for acute hospital care only.

Premiums

Premium rates have been increased twice since the original introduction of hospital insurance and these increases have not been well received by the public. Naturally, increases were necessary to meet growing costs of the scheme and to enable it to stand on its own feet; but there was a loud clamour from the public for further subsidization from general tax revenue*

Premium rates at the time of writing are:

Single person	$30.00 per annum
Family groups	$42.00 per annum
(including many dependent relatives)	

The premium charges do not appear to reflect a realistic approach to the financing of the scheme but premium rates and collection policies represent a special study; and this article is primarily a summary of the hospitals' position in regard to compulsory insurance.

Operating Results

After three and a half years of operation it can safely be said that the major effect of hospital insurance, from the hospitals' viewpoint, is that the hospitals are assured of a basic income at the first of the year. This permits them to proceed with the year's operation with a good knowledge of their expected revenue. Budgeting has become the most important factor in the financial control of our hospitals. In this respect, of course, the position of the hospitals is somewhat similar to that of other necessary community services. To achieve this result the hospitals have had to submit their budgets to the Hospital Insurance Service for approval before the beginning of the year; and deductions have been made by the B.C.H.I.S. which have not pleased the hospitals. However, approved budgets may be reviewed with the Service if the parties are not in agreement and, with certainty, we can say that the hospitals have lost less than they have gained.

Hospitals are no longer pauperized. The communities have generally risen to the occasion by taking renewed interest in their hospitals because it is realized that extra funds will be used for the expansion of services and not for the payment of debts already incurred. In many cases the municipalities have been relieved of large financial burdens. Generally speaking, the financial attitude of the community towards the hospital has changed. The hospital is no longer regarded as a necessary burden. It has become a living part of the community along with other public services.

It is noteworthy that the contributions by the women's auxiliaries have shown a steady and gratifying increase since the advent of the insurance plan. As a matter of fact, the membership of the auxiliaries has almost doubled. This interest on the part of the women of our communities is essential to a good hospital program and has been stimulated through renewed interest in hospital facilities generally. The contributions made by the government to supplement donations from the auxiliaries have been of great assistance.

Hospital administrators admit that without the insurance scheme they would be quite unable to continue to provide their present standard of service. But, at the administrative level, all is not smooth sailing; nor could it be expected that the scheme would function without hitch in its formative period. Some administrators have decried the red tape and certain of the policy decisions made by the insurance officials. Nevertheless, it is the writer's firm opinion that there has been no interference with the management of our hospitals and the Insurance Service officials only presume to offer advice to hospitals in those cases where the hospitals have sought advice —except in the planning of new construction, which must be approved by the Service. Nevertheless, the relationship between hospitals and the Insurance Service has generally been very cordial and serious disputes really play an insignificant part in the results achieved to date.

It must be realized that the administrative difficulties encountered in establishing the insurance plan in such a short time have been tremendous. The registration of all the population, the approval of hospital claims for services rendered to beneficiaries, statistical reports and finances and the approval of hospital budgets, together with the control of plant facilities, are the salient factors of an organization that started from scratch.

It was probably inevitable that the original Commissioner and some of his closest associates resigned after a great deal of the spade work was completed, as it was such a difficult task and the time was limited. At any rate, after something more than a year of operation, a young executive of proved ability, Lloyd F. Detwiller, who had a sound knowledge of economics and public financing, was transferred from the Treasury Department of the Provincial Government and was appointed Commissioner. Donald M. Cox, a highly respected hospital administrator from Manitoba, was appointed Assistant Commissioner in Charge of Hospital Services. Under their guidance the scheme has continued to flourish and many necessary amendments have been made. To their credit, by the way, it should be reported that in the third year of operation the total expenses of the insurance plan were well within the approved estimates.

During the early stages of the inception of the plan an excellent community survey was made by James A.

(Concluded on page 90)

**This article prepared previous to recent changes in rate structure. For new rates see page 66.*

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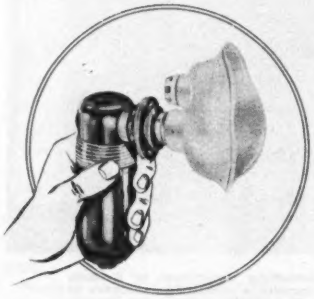

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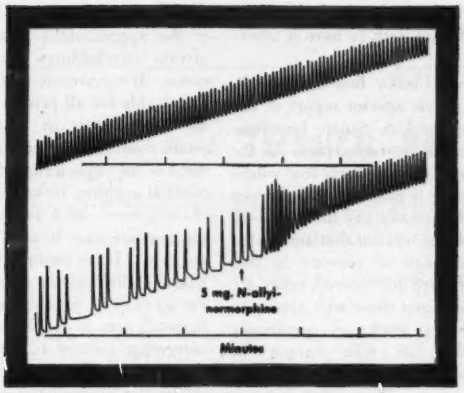

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Literature available

[1]Eckenhoff, J. E., Elder, J. D., and King, B. D., *Am. J. Med. Scs.* 223:191, February 1952. [2]Eckenhoff, J. E., Hoffman, G. L., and Dripps, R. D., Annual Meeting of the American Society of Anesthesiologists, Washington, D. C., Nov. 8, 1951.

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B.C. Hospital Insurance

(Concluded from page 86)

Hamilton and Associates of Minneapolis and this survey should serve as an excellent guide for the expansion and improvement of hospital facilities in the province in the future. New programs are not being carried out in a haphazard manner.

Conclusion

Hospital insurance was introduced into British Columbia at the wish of the people. After a year of operation there was a public outcry against the amendments which were passed by the legislature. The political implications of the amendments took some prominence in the resulting furore raised by the press and organized groups. Since that time, however, the people seem to have accepted the fact that hospital costs and hospital services have increased and that this province is not out of line with the rest of Canada in the problem which must be met. It is significant that during the recent provincial election the political parties supporting the compulsory aspect of hospital insurance received the greatest number of votes. The new government feels that there may be less compulsion in the scheme but no comments can be made at this time as the government has not taken office as this is written. Hospital insurance was not the only contentious item in the political campaign and thus it is difficult to measure definite results from the election. Certainly, none of the parties saw fit to propose the elimination of the insurance scheme. The prepayment of hospital care in the Province of British Columbia is here to stay and the hospitals would not wish to have it otherwise.

The Dean Clarke Report, recently published as an interim report of the findings of the U.S. Senate investigation of health insurance plans in the United States, shows clearly that voluntary insurance is paid by those persons who would normally pay for their own care. It also points out that among the large percentage of persons in that country who are not covered, many are the itinerants and those who appear to have a lesser sense of community responsibility or who cannot be reached on a group basis. In the forward to the report Dean Clarke and his associates say, in part:

"There are differences of opinion as to what portion of the costs of medical care should be considered insurable and as to what groups of the population can or should be enrolled. If we assume that all of the costs of physicians' and general hospital services now supported by private expenditures may be insured through voluntary plans, the $755 million paid in benefits by all forms of medical-care insurance in 1949 constituted about 17 per cent of the approximately $4.4 billion in private expenditures for these purposes. If we assume that insurance is practicable for all private expenditures for the services of physicians, hospitals, dentists and nurses, and for one-third of the expenditures for drugs and medical supplies, including the net cost of insurance—$6.4 billion in 1949—the amount now insured is about 12 per cent. If we assume that only five-sixths of the private expenditures for the services of physicians and general hospitals may or should be insured, the percentage insured in 1949 was about 21 per cent. Conversely, by the highest of the above estimates, *voluntary insurance plans do not cover about 80 per cent of that portion of the nation's medical-care bill generally regarded as the minimum that is potentially insurable.*"

It would appear from this report that, without compulsion or some better voluntary method than has been found to date, hospitals will be unable to meet rising costs to provide for the demands of the public for hospital care.

THE CANADIAN HOSPITAL

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Medicine as Understanding

Most men form an exaggerated estimate of the powers of medicine, founded on the common acceptation of the name, that medicine is the art of curing diseases. That this is a false definition is evident from the fact that many diseases are incurable, and that one such disease must at last happen to every living man. A far more just definition would be that medicine is the art of understanding diseases and of curing or relieving them when possible. Under this acceptation our science would, at least, be exonerated from reproach and would stand on a basis capable of supporting a reasonable and durable system for the amelioration of human maladies.

—Dr. Jacob Bigelow

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BRANCHES ACROSS CANADA

Mobile Clinic Service in Australia

(An excerpt from an article which appeared in "Hospital and Health Management," London, Eng., March, 1952.)

"TO HELP MOTHERS and save babies" is the motto of the Australian Mothercraft Society with headquarters in Sydney, the capital of the state of New South Wales. To this practical end the society has introduced a mobile clinic service to bring expert advice and assistance to mothers and babies in the outer metropolitan districts of Sydney.

The first of its kind in New South Wales, the sky blue and white vehicle was put on the road in July, 1951. It is attractively finished with pale blue venetian blinds, and red leather chairs, and contains a refrigerator, storage cupboards, spirit stoves for heating and sterilizing, as well as other necessities. Full clinical work is carried out, including test feeding and baby training.

Now a familiar sight in Koringgai-shire, the clinic caters to districts not serviced by the baby health centres controlled by the state government. It is a boon to women who find it difficult to go to a regular clinic. On the road five days a week from 10 a.m. to 3.45 p.m., the clinic is in the charge of a mothercraft nurse who specializes in infant welfare. Several days a week the nurse travels between 45 and 50 miles from the base at Gordon to visit Beacon Hill and Boulkham Hills. Most of the people who live in these outlying metropolitan districts have small mixed farms, raise poultry or grow fruit and a fine trip of more than six miles is usually necessary to reach the nearest baby centre in the township of Parramatta.

It cost £A 1,500 to put the clinic on the road and running costs are estimated at £A 1,000 a year. Garaging and servicing is provided free of charge by a northern suburb garage. Attendance figures are increasing and it is hoped that, with the success of the first venture, another mobile clinic can be put into operation. In July, 1951, the first month the clinic was on the road, 153 mothers and babies visited it; the number had grown to 305 in August, 328 in September, and 472 in October. Another sharp increase was noted in November of that year.

The Australian Mothercraft Society, which was founded in 1923 by the late Sir Truby King, maintains 15 clinics in the metropolitan area of Sydney. Two of these are located in big department stores — one in the heart of Sydney and the other in the beautiful harbourside suburb of Manly, eight miles from town across Sydney harbour. The society is financed by voluntary subscriptions and mothers pay the small fee of 2s. 6d. when they visit the clinics.

Although this mobile clinic is the first of its kind in New South Wales, there are two similar clinics operating in the southern state of Victoria. These are subsidized by the Victoria State Government and travel continuously through outback rural districts. ●

Centralized Food Service

(Concluded from page 50)

are carried out in the large central kitchen.

The belt assembly line on which all trays are made up to serve the patients (see ill.) is systematic and logical as it is a counterpart of the assembly line techniques employed in industry. Each employee has her own special duty on the assembly line which she has been trained to perform. As the belt is set into motion, empty trays are placed on it about three inches apart and while the tray travels along, tray covers, serviettes, sugar, salt and pepper, menus, silver, deserts, salads, hot foods, plate covers, cups and saucers, tea or coffee, hot water, and ice cream are placed upon them in this order. By this time the tray has reached the shaft and is then vertically transported to the floor designated by a dial. One dietitian checks the tray half way along the line and a second dietitian gives a final check to see that the food on the tray conforms with the selective menu just before it continues up the shaft. Special diets are prepared in advance and are sent along with the other trays.

It is the responsibility of the nursing department to deliver the trays to the patients, as this phase is considered a part of complete patient care. It is for this reason that the supervisor checks the trays as they are removed from the trayveyor by the porter. Although the nursing staff is augmented by maids from the housekeeping department, in this connection, it is the supervisor who decides whether the tray should be delivered to a specific patient by a nurse or a maid. It is the condition of the patient that determines this decision. For example, if a patient has to be fed, a professional nurse or a practical nurse would deliver the tray rather than a maid; whereas if the patient is convalescing it is then delivered by a maid.

For each floor this duty takes only from five to eight minutes depending upon the number of patients, as they are served at the rate of seven per minute or approximately 210 in half an hour. It takes less than three minutes for a tray to travel from the starter's position on the assembly line until it reaches the patient's bedside. After the meal, the used dishes are sent back to the kitchen by means of reversing the conveyor mechanism.

Experience has proved that the food can be served to the patient hot, when indicated, and always appetizing. The trayveyor system will only break down if the organization is weak and under such circumstances no system will work properly. It may be emphasized that food waste was reduced by ninety per cent after the foregoing system was put into effect and other economies were most apparent as a result of the elimination of food in the floor pantries.

Actually, the principle of centralization has also been adopted by providing only one dining room for all employees, professional or otherwise. Furthermore, the policy of selective menus is being carried out in the cafeteria (see ill.) which is unlimited in scope because all employees, including student nurses and interns, pay for their meals.

No Need for Glory

Men, steered by popular applause, though they bear the name of governors, are in reality the mere underlings of the multitude. The man who is completely wise and virtuous has no need at all of glory, except so far as it disposes and eases his way of action by the greater trust that it procures him.
—Plutarch

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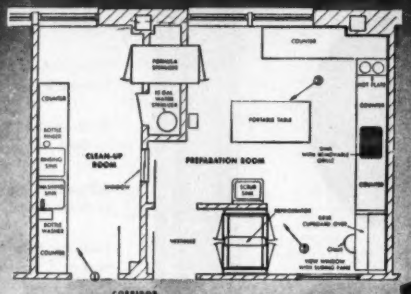
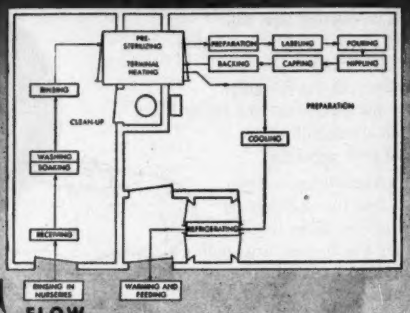
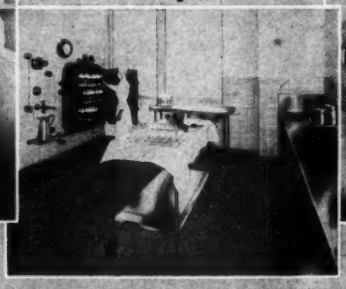


PLAN VIEW



FLOW CHART

CLEAN-UP



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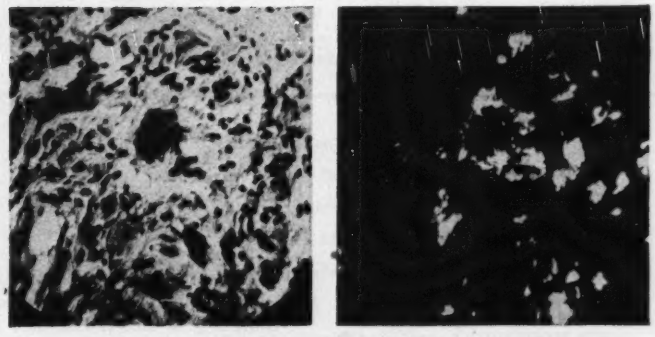

Talc granulomas in myometrium. Identical fields: left, under ordinary; right, under polarized light.

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Dietary Nomenclature

When dietetics was a new profession and when the work was comparatively limited in scope, dietitians probably had no great difficulty in understanding one another. Now, as a result of rapid growth, both in numbers and in professional activities, they do not always "speak the same language".

A study by the diet therapy section of the American Dietetic Association of twelve diet manuals published between 1948 and 1951 showed that dietary nomenclature is improving but much more has to be done. Therapeutic dietitians are especially concerned with the proper naming of diets. Probably the major obstacle in arriving at a satisfactory name for a diet is the lack of complete information concerning food value and the behaviour of food in the body. The restricted sodium diet, currently so popular, is an instance where information on food values is incomplete or not widely appreciated and where the literature is expanding so rapidly that many have not had an opportunity to keep abreast of change.—*Journal of the American Dietetic Association, July*, 1952.

Coming Conventions

Oct. 16-18—Associated Hospitals of Alberta Convention, Palliser Hotel, Calgary.

Oct. 18-19—Ontario Society of Radiographers Convention, Chateau Laurier, Ottawa.

Oct. 22-24—Associated Hospitals of Manitoba Convention, Royal Alexandra Hotel, Winnipeg.

Oct. 26-29—Annual Convention of the Women's Hospital Auxiliaries Association, Province of Ontario, Royal York Hotel, Toronto.

Oct. 27-29—Ontario Hospital Association Convention, Royal York Hotel, Toronto.

Oct. 30-31—Annual Convention of the Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto.

Canadians at International Congresses

Two staff members of the Montreal General Hospital, last month represented Canada at first international congresses in their fields. Dr. C. Miller Fisher, the hospital's neuropathologist, attended the first International Congress of Neuropathologists, at Rome, from September 6-13th, and Frank Zahalan, chief pharmacist at the hospital, attended the first World International Congress of Hospital Pharmacists, at Basle, Switzerland, from September 17-19th.

Dr. Fisher, who is also on the staff of the Montreal Neurological Institute and is consulting neurologist at Queen Mary Veterans' Hospital, presented to the congress the results of his research into the nature and cause of mental changes that take place in elderly people. Mr. Zahalan, who is a member of the advisory council of the Canadian Society of Hospital Pharmacists, was delegated by his Society to attend the congress at Basle.

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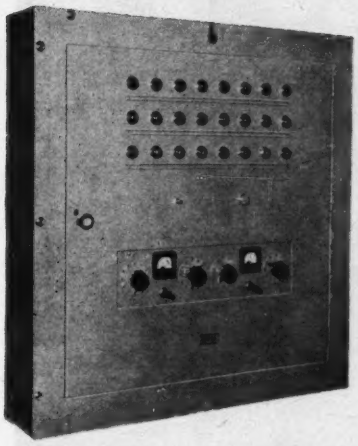

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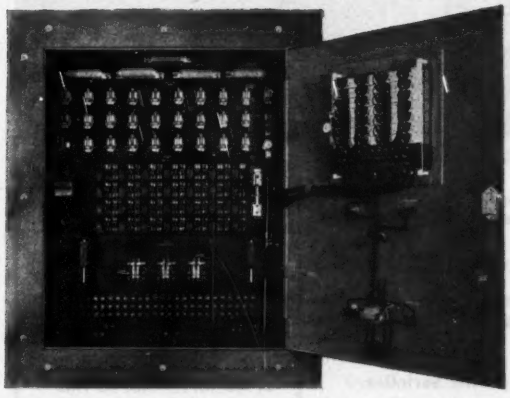

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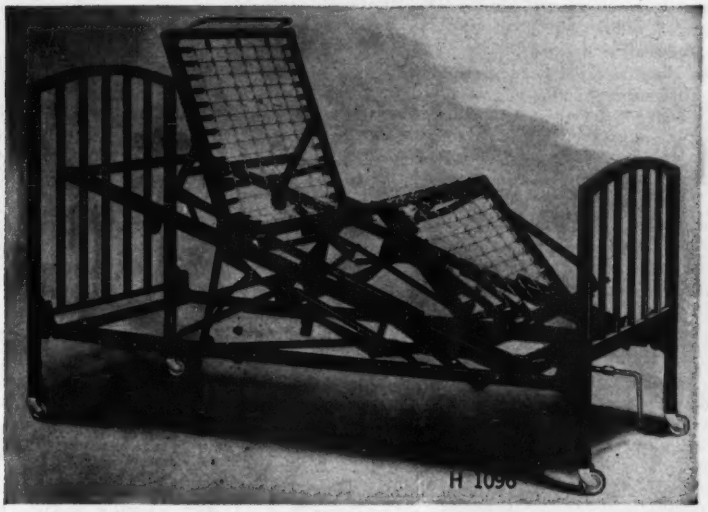

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A.H.A. Convention

(Concluded from page 56)

erica's Town Meeting of the Air", which was broadcast from the convention hotel. Anthony J. J. Rourke, M.D., president of the Association debated the question "Can Hospital Costs Be Lowered?" with Eli Ginzberg, author and economist, Columbia University.

New Officers

Dr. Edwin L. Crosby, formerly director of The Johns Hopkins Hospital, Baltimore, Maryland, and now executive director of the new Joint Commission on the Accreditation of Hospitals, assumed the presidency of the Association at the banquet held on Wednesday evening. Ritz E. Heerman, superintendent of the California Hospital, Los Angeles, Cal., was unanimously chosen as president-elect of the American Hospital Association, his term of office to begin after the 1953 convention. Dr. Arthur C. Bachmeyer, director emeritus of the University of Chicago Clinics, was re-elected treasurer. Three new trustees were selected: Dr. J. Gilbert Turner, executive director of the Royal Victoria Hospital, Montreal; Robert S. Hudgens, administrator of the Lynchburg (Va.) General Hospital, Lynchburg, Va.; and Tol Terrell, administrator of Shannon West Texas Memorial Hospital, San Angelo, Tex.

Civil Defence and Fire-Fighting

The urgency of organizing for civilian defence is dramatically demonstrated in the new British film—"The Waking Point". Produced by the Crown Film Unit for the United Kingdom Central Office of Information, "The Waking Point" is designed to win recruits for civil defence. By means of a dramatized story, it shows the need for recruits and the facilities available for training them.

Another film, "Fire's the Enemy", concerns Britains' Auxiliary Fire Service and demonstrates recent developments in training and equipment, the possible emergencies, and how the organization deals with a serious outbreak.

Both films are in black and white, with a sound track, and are available in both 35 mm. and 16 mm. prints. They can be purchased or rented from the United Kingdom Information Office, 275 Albert St., Ottawa. The sale price of "The Waking Point" is $55 and its running time is 20 minutes. "Fire's the Enemy" sells for $30 and has a running time of 10 minutes.

Australian Government's Health Scheme

The Australian Government has announced the inception of a Medical Benefits Scheme which is expected to be in operation early in January of next year. The government is launching this scheme in conjunction with benefit societies, each side contributing equally to the cost of service. Final details have not yet been worked out, but it is envisaged that the plan will be divided into two parts, a minimum and an optional schedule. The minimum schedule will cover all ordinary medical work which is performed by the medical practitioner. Insurance under this schedule will provide coverage for doctors' visits, midwifery, simpler operations, simpler types of anaesthetics, and vaccinations. The optional schedule includes the more difficult operations and work generally done by a specialist, as well as pathological services.—*Hospital and Health Management.*

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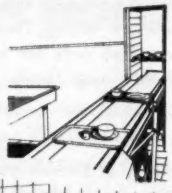

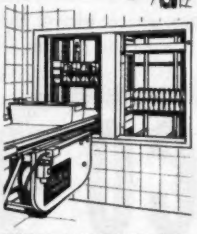

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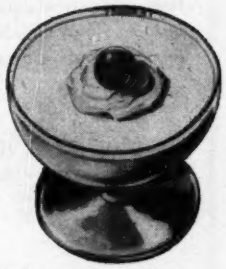

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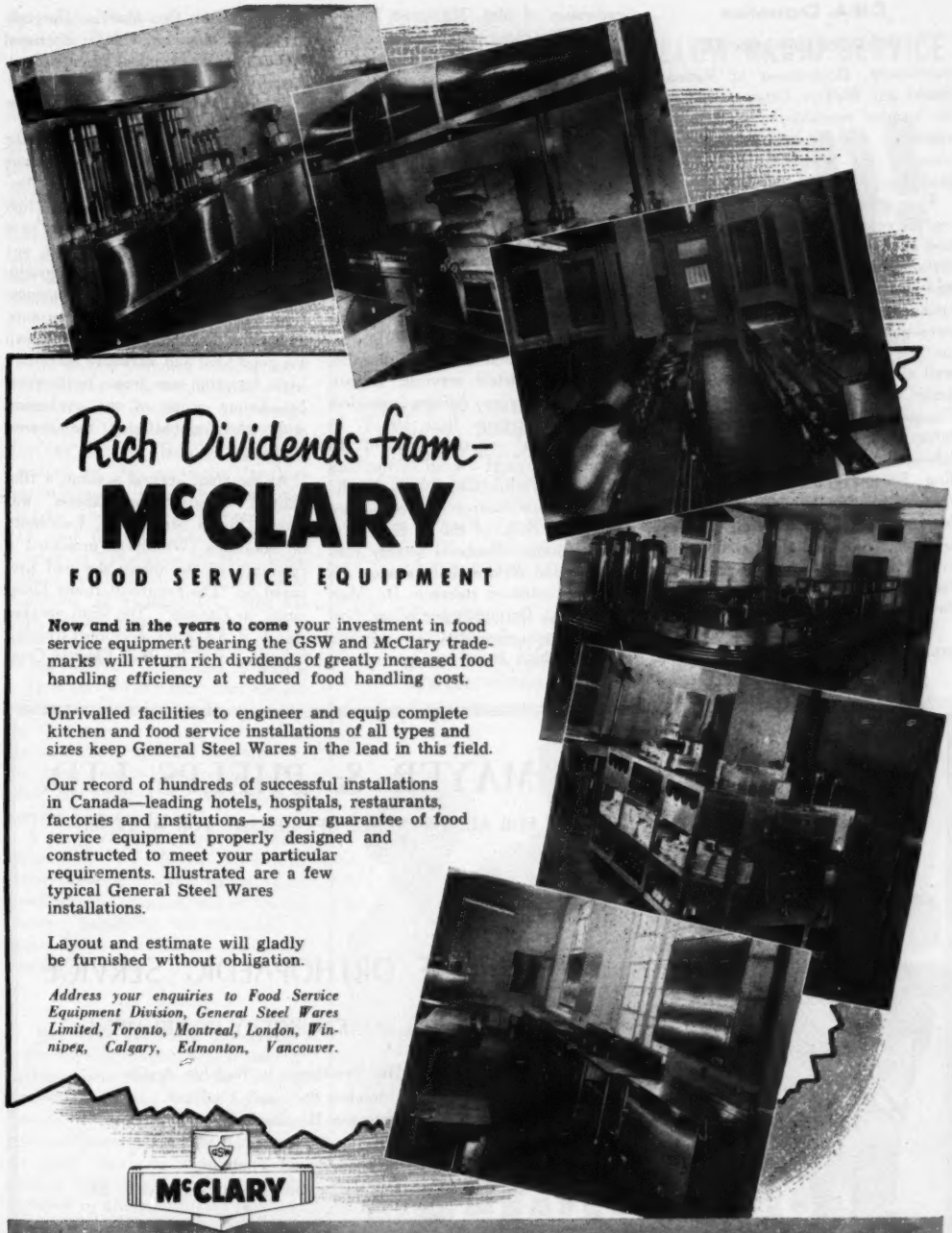

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C.D.A. Convention

(Concluded from page 52)

nutritionist, Department of National Health and Welfare, Ottawa, discussed the hospital consultation services provided by the department and listed some of the pamphlets and movies available.

Four group meetings were held during the convention. At the administration and personnel group, Alberta Macfarlane, consultant for food operators and manufacturers, Chicago, Ill., spoke on cost control and management, stressing the importance of job analysis and time and motion studies, as well as sanitary and accident control. Jessie Naismith of the Bell Telephone Company told how kitchens and cafeterias could be planned so as to save labour and motion. Miss Evelyn Walling, Burnaby, B.C., emphasized the need of continuous staff training and Mrs. Margaret Dillabough, Kelowna General Hospital, Kelowna, B.C., described the advantages and disadvantages of unions in the labour relations field.

The "home economists in business" group met for discussion under the leadership of Mrs. Marianne Linnell of *The Vancouver Sun*. At the community nutrition group, methods of furthering nutrition education were discussed by Doris Noble, Department of Health, Victoria, B.C., Rosamund Ross, Metropolitan Health Committee of Vancouver, Elva Perdue, Department of Health, Edmonton, and Margaret McKellar, Toronto, under the chairmanship of Ruth Moyle, Toronto Department of Public Health. The education section was chaired by Mabel Patrick of the University of Alberta.

An evening session was held in the auditorium of Shaughnessy Hospital (DVA) at which Jean Macdiarmid, director of dieteic services, Department of Veterans Affairs, presided. Following greetings from Dr. T. D. Bain, medical superintendent of the hospital, Margaret Terrell of the University of Washington, Seattle, Wash., spoke on cost control in food service and Helen Buik, of the T. Eaton Co. Ltd., Toronto, discussed quality control in food service. In a session devoted to nutrition research, Dr. Margaret Finke, Oregon State College, Corvallis, Oregon, described two nutrition surveys which had been carried out in her state. Dr. Marvin Darrack, Faculty of Medicine, U.B.C., discussed some of the biochemical aspects of nutritional research.

"Through the Looking Glass—Careers in Home Economics" was the subject chosen by Alberta Macfarlane for her luncheon address. Miss Macfarlane reminded her audience that only during the past 30 years have there been women in business to any great extent. Home economics graduates were urged to enter the business field, operate their own restaurants, and make them internationally known for good food and attractive surroundings. Attention was drawn to the ever-broadening scope of the profession with television offering the newest challenge.

At the final general session, a film entitled "Spotlight on Careers" was shown. Isabel MacArthur, University of Manitoba, Winnipeg, presented a summary of the thesis she had prepared on "The Future of Home Economics in Canada". The final speaker was A. R. Kluckner, personnel training department of the B.C. Electric Com-

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pany Ltd., Vancouver. He told of his experiences in selecting and training personnel and also described his methods of keeping production high with good employer-employee relations.

Association business was discussed at the board meeting before and after the convention. Committee reports were received for the approval of the Board of Directors and were presented in summarized form to the members at the annual meeting. Isabel MacArthur, the newly appointed director of the School of Economics of the University of Manitoba, was elected president for 1952-53.

The annual banquet, coming as it usually does on the last evening of the convention, provided an impressive conclusion. The president, Edith Wark, Toronto Western Hospital, Toronto, presided on this occasion. Greetings were brought from the American Dietetic Association by Margaret Terrell, and from the Canadian Home Economics Association by Mary Hiltz, University of Manitoba. Dr. Henrietta Anderson, of Victoria, B.C., who has been active in education work for forty years gave an excellent address, chosing as her subject, "Values and Standards —So What". In this age where the emphasis seems to be on how to make the most money with the least effort, Dr. Anderson expressed concern over the changes which have gradually taken place and stressed the importance of keeping high standards.

A most efficient convention committee with Paula Reber of the Vancouver General Hospital as chairman, a well-planned program, and traditional western hospitality, all combined to make this convention an outstanding success.

New Flour and Bread Standards

An order-in-council, passed June 30, outlines new standards for various types of flours and breads for use in Canada. These standards will become effective January 1st, 1953. Some of the most significant regulations, beginning next year, are: flour may be enriched by the addition of thiamine, riboflavin, niacin, and iron. Any bread described as whole wheat must contain not less than 60 per cent whole wheat flour. Brown bread made with less than 60 per cent whole wheat flour or with no whole wheat flour must be so labelled. — *"Nutrition Notes", September,* 1952.

Book Reviews

(Concluded from page 78)

listing successful ideas and methods. Large and small hospitals were surveyed and their problems studied. As a result, the *Manual of Hospital Housekeeping* is an important new contribution to the literature in this field and should be a valuable addition to every housekeeper's and administrator's library.

HANDMAID OF THE DIVINE PHYSICIAN, The Religious Care of the Sick and Dying. By Sister Mary Berenice (Beck), O.S.F., R.N., Ph.D., professor of nursing education and director, department of nursing education, Graduate School, Marquette University, Milwaukee, Wisconsin. Pp. 311. Price $3.00. Published by the Bruce Publishing Company, Milwaukee, Wisconsin.

This book is a revision of *The Nurse, Handmaid of the Divine Physician* which first appeared in 1945. It was designed to meet the need for a text or reference book which contained, in brief and simple form, all the necessary knowledge and directions for the nurse and other workers among the sick regarding the spiritual care of patients from the Catholic point of view. In this revision, the content has been changed and re-arranged. To keep the book small and still make room for additions, some of the former content has been omitted, such as the stories demonstrating the use of religious aids for patients, and most of the Latin prayers accompanying the administration of the sacraments. The English version remains. The additions include the sacrament of confirmation; a discussion of suffering; the Ordinary of the Mass; and various prayers.

Handmaid of the Divine Physician was prepared primarily for student nurses to be handed to them when they begin their nursing course and to be carried with them into classroom, ward, and chapel for use as textbook, reference, or prayer book, according to the needs of the moment. It is also intended for those who, after graduation, wish a reference for professional use combined with devotions which may also be personally useful. Practical nurses, too, and those who care for the sick in any capacity should find it helpful.

"Your Money's Worth in Health"

A brief but attractive and accurate answer to the why of rising costs for medical and hospital care is the booklet prepared by the American Hospital Association and called "Your Money's Worth in Health". Excellent use has been made of colour, design, and illustrations in this booklet to intrigue the attention and interest of the average reader.

The price paid for the doctor's care is compared with the price paid for other necessities of life, such as bread and fuel, both ten years ago and today. The booklet points out that the doctor actually receives less of the medical dollar today than formerly. When it comes to hospitals bills, the booklet show that, although hospital costs and therefore bills are higher, hospital stay is shorter on the average than ever before. As a result, the total hospital bill is often lower than it would have been any time in the past.

Timely and well prepared, "Your Money's Worth in Health" should, itself, be worth much in promoting good public relations.

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Neurological Institute

(Concluded from page 33)

visitors, and staff, are the sun galleries which will command an interesting view of the city.

The Montreal Neurological Institute, an integral part of McGill University, works in close co-operation with the Royal Victoria Hospital from an administrative point of view. It also has close professional relationship to the other general hospitals in the city and members of its staff are also on the staffs of general hospitals. In commenting upon the new wing, the director of the institute, Dr. Wilder Penfield, said: "The need for construction of a wing was placed before the friends of the Montreal Neurological Institute two years ago. The first estimate of building costs was $1,400,000.

"During more than a year, we have worked continuously with the architects, Fetherstonhaugh, Durnford, Bolton, and Chadwick, perfecting the plan in every detail, but without further enlargement. Now, to our consternation, the final estimate of costs is about $900,000 more than the original estimate. Nevertheless, construction of the wing is about to begin.

"From the time of the founding of the Institute, the provinical government has encouraged and supported our clinical work, seconded in this by the City of Montreal. More recently, the federal government has supported a large proportion of the research which was started in the laboratories by the Rockefeller Foundation of New York. The support of research was increased by many individuals.

"Before long, this city, this province, and this nation, will be served by a clinical institute which is organized for permanent leadership in the field of medicine where the need is greatest; for solutions of the problems of the nervous system, the brain, and the mind, may do much to change the world we live in."

The contract for the new addition has been let and a start has been made on preparatory work, such as the demolition of the temporary military annex. Contractors are J. L. E. Price and Co. Ltd., and with the architects are McDougall and Friedman, as consulting engineers. ●

National Conference Held On Civil Defence Welfare Services

A Federal-provincial conference on Civil Defence Welfare Services was held in Ottawa from Sept. 9th to 13th. This meeting was the first of its kind and was designed to study services which have already been developed and to explore future plans on federal, provincial, and muncipal levels.

Among the many questions discussed were: the development of civil defence welfare services in the United States; emergency welfare services in England during World War II; purpose of welfare services in civil defence; role of welfare organizations and agencies; personnel required; mutual aid and mobile teams; and recruiting, training, and communications.

The conference was under the chairmanship of R. B. Curry, head of the federal civil defence welfare planning committee.

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Manitoba Health Survey

(Continued from page 68)

ister of National Health and Welfare. The study, financed by a federal grant, supports the principle of a health insurance plan for Canada but suggests that priority be given to the preventive medical services now being set up in Manitoba under the province's own health plan.

The committee endorses the basic principles of a plan of health insurance for Canada as enunciated at the Dominion-provincial conference of 1945 and urges that any prepaid health plan should be introduced by gradual stages and be flexible enough to permit adaptation to varying conditions in the province. It recommends that any health insurance plan should be provincially administered, contributary on the part of all participants who are able to subscribe; and urges that existing non-profit voluntary agencies already providing prepaid medical and hospital care should be used as extensively as possible. The committee stresses the necessity of avoiding the difficulties and abuses that have developed in prepaid health plans elsewhere and urges that, so far as possible, such a plan should be on a voluntary basis.

The Manitoba health plan, for which priority is urged, provides for (1) preventive medical services by establishment of local health units; (2) diagnostic services through laboratory and x-ray units; (3) prepaid medical services by municipal doctors; and (4) hospital facilities through establishment of organized hospital districts.

It is noted in the report that eight new health units have been set up since 1946 and two older districts have been enlarged. The committee endorses the provincial health department's plan to reduce the maximum number of units to 15, thereby enlarging the area and population of both existing and proposed units and reducing the direct cost per capita. The committee suggests that private physicians be encouraged to assist in the work of the health units by giving immunizations and medical examinations and attending child health conferences on an hourly or fee-for-service basis.

Although development of prepaid x-ray and laboratory services has been hampered by lack of trained technicians and professional consultants, the committee endorsed the idea and urged extension of this type of service as fast as the supply of personnel permits.

Some 18 doctors are practising in rural areas under contract with certain municipalities and the committee recommends that "serious consideration" be given to subsidizing resident doctors in the more outlying areas.

In its survey of dental health conditions, the committee recommends that arrangements be made to subsidize the education of selected dental students with a written agreement that they will, after graduation, practise for at least three years in a rural area and devote a substanial part of their time to children's dentistry. Rural areas needing a dentist should provide office space and basic equipment, the report recommends, with the object of encouraging a private dentist from a nearby town or city to visit the area periodically.

The committee recommends refresher courses for doctors taking part-time work in health units and conferences to acquaint the medical profession with the uses of prepaid labora-

tory services. It suggests an expansion of training facilities for laboratory technicians; urges that Manitoba and Saskatchewan unite to provide a school of dentistry to serve both provinces; and suggests federal bursaries for training dental hygienists who will assist in the preventive program of rural dental clinics.

More than a score of recommendations are included concerning hospitals, their personnel, and training facilities, and private duty nursing. The committee recommends that requests for small general hospitals under 16 beds be reviewed "very critically" and that they be authorized only under special circumstances.

The report suggests that the merits and availability of home nursing services as provided by the Victorian Order of Nurses and licensed practical nurses should be intensively publicized. It asks the V.O.N. to investigate the need for a service in Brandon, Dauphin, The Pas, and Flin Flon, and recommends that provincial and municipal financial support be given to the V.O.N. in providing this service in areas where it is needed.

Regarding the shortage of nurses, the committee recommends that the Manitoba Medical Association promote "the more discriminate use of professional nurses" and the employment of licensed practical nurses and technicians as office assistants. It urges establishment of federal bursaries for nurses-in-training and suggests closer co-operation among nursing schools so that girls who cannot meet the qualifications for professional nurses might have a chance to qualify as practical nurses.

In its section on mental health, the committee urges extension of preventive mental health services, including clinics, and the extension of facilities at the Psychopathic Hospital and the provincial mental hospitals.

The committee recommends two surveys: one to determine the amount and type of pre-natal care received by expectant mothers; and a second to find out the numbers of aged persons needing care, the number suffering from chronic diseases who need institutional care, the extent and quality of care now being provided by private agencies, and ways and means of meeting the needs of the aged and infirm and of rehabilitating younger persons with chronic illnesses.

Another recommendation urges that

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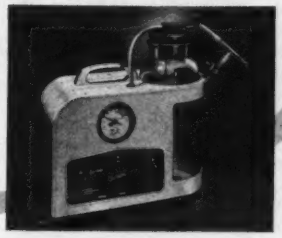

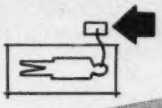

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parents be given more information about school health programs as a means of ensuring that the physicians' recommendations regarding each child's health are carried out.

The Manitoba survey was directed by Dr. M. R. Elliott, deputy minister of health and public welfare. The survey committee included representatives of the Manitoba Medical Association, the Manitoba Dental Association, Manitoba Pharmaceutical Association, Manitoba Association of Registered Nurses', Hospital Council of Manitoba, Welfare Council of Greater Winnipeg, Manitoba Federation of Agriculture, Union of Manitoba Municipalities, Women's Institutes of Manitoba, the advisory commission under the Health Services Act, Winnipeg and District Trades and Labour Council, Winnipeg Central Labour Council O.B.U., Canadian Congress of Labour, Associated Hospitals of Manitoba, and six members-at-large. ●

Physicians' Art Salon

(Concluded from page 39)

Dr. I. A. Schlesinger, Outremont, P.Q.
"Reflections — Bearskin Neck, Mass."
Dr. R. F. Ross, Truro, N.S.
"Atlantic Fog"

Monochrome Photography

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Dr. C. M. Spooner, Toronto
"The Pottery Market"
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Dr. B. S. W. Brown, Granby, P.Q.
"Frosty Sunday, 6 a.m."
Third Prize
Dr. W. K. Blair, Oshawa, Ont.
"Where Ships Once Came"
Awards of Merit
Dr. H. F. P. Grafton, Kamloops, B.C.
"The New Baby"
Dr. C. B. Hatfield, Edmonton, Alta.
"All My Love"
Dr. H. C. Knox, St. Thomas, Ont.
"Old Man"
Dr. E. D. MacCharles, Medicine Hat, Alta.
"The Bountiful Prairie"
Dr. E. V. Spackman, Lethbridge, Alta.
"Winter Filigree"

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Dr. W. A. Davies, Invermere, B.C.
"Rainbow in the Storm"
Second Prize
Dr. H. Brooke, Vancouver
"Passing Storm"
Dr. G. C. Willis, Montreal
"The Young Angler"
Awards of Merit
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"Chutes Ste. Anne"
Dr. N. T. Bennett, Chemainus, B.C.
"Hallowe'en"
Dr. Claude Bertrand, Montreal
"Joie de Vivre"
Dr. Bruce Charles, Toronto
"Evening, Lake Simcoe"
Dr. Charles DeTorregrosa, Jonquiere, P.Q.
"Le Chant du Bois"
Dr. M. A. Entin, Montreal
"Reflections"
Dr. M. Katz, Haney, B.C.
"Mirror, Mirror"
Dr. Jean Marc Morin, Drummondville, P.Q.
"Galeries des Glaces"
Dr. W. R. Read, Drumheller, Alta.
"Forty Below"
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"The Pool"
Dr. K. J. Williams, Invermere, B.C.
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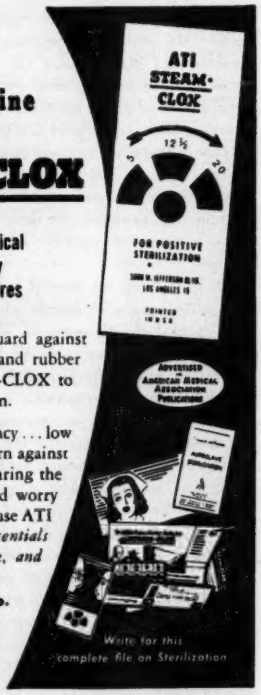

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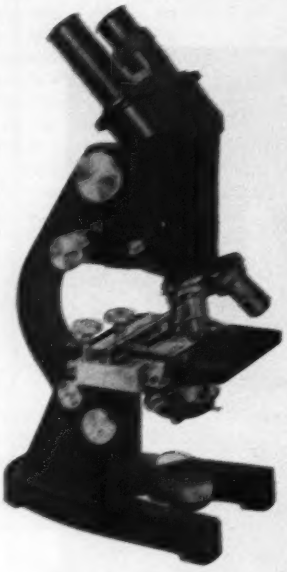

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Treating Communicable Diseases

(Concluded from page 31)

organize the educational program for interns. He would have close liaison with the medical officer of health who, as a member of the medical staff of the hospital, would work closely with the chief of the medical staff and the administrator in recommending and following up proper facilities for the care of these patients and the promotion of the public education program.

Demands Upon Special Services

In the admission of this type of patient to the general hospital, the administrator must recognize the fact that added responsibilities, and loads, will be placed upon certain hospital services. In addition to those departments already mentioned, nursing, dietary, and housekeeping, there will be extra demands placed upon special services such as clinical laboratory and physical medicine. Although the former will play its role mainly during the early stages of the disease, the departments of physical medicine, physiotherapy, and occupational therapy will have extra demands during the convalescent period, for part of which the patient may still be in isolation. This will necessitate education of another type of personnel for adherence to isolation regulations and procedures. After the isolation period when it is still necessary for the patient to have supervision and treatment, transfer to another unit may be necessary and rehabilitative activities continued there. These special departmental services are a part of the treatment and care of many patients with communicable diseases. The fact that the departments are already well organized and staffed by qualified personnel, in the general hospital, will direct attention to the prescribing and carrying out of these services of re-education, in the best interests of this special type of patient who wishes to become again a useful citizen in the community.

Poliomyelitis

For several years patients suspected of having poliomyelitis have come to general hospitals for confirmation of diagnosis. Where facilities are adequate these patients are admitted for treatment and care. It is true that one never knows where, when, or how, poliomyelitis may strike a community, and the general hospital with its facilities for isolation and equipment for care must always be prepared. The hospital administrator may justly ask, "How far should we go?". This is a difficult question to answer for it involves organization of a team composed of representatives of medical staff in such specialities as paediatrics, medicine, orthopaedics, neurology, and physical medicine; nursing staff, with knowledge of special equipment, for 24-hour care of these patients during the acute stage of the illness; therapists for re-education and rehabilitative services, as well as informed non-professional staff. It will necessitate increased space for special equipment used in the care of these patients, as well as planned electrical and plumbing utilities to facilitate use of special treatment equipment. Last, but by no means least, a public education program will be needed to give the community a better understanding, yet not an alarming concept, of the diseases and help to allay the panic-like fears of all concerned. The actual care of patients with poliomyelitis can then be carried on according to the treatment prescribed within the communicable disease unit in the general hospital.

Educating the Public

Probably the most important feature in the care of patients with communicable diseases in the general hospital is an organized continuing program of public education. No longer do we need to consider these diseases as a speciality, but rather as one type of medical disease. Education through health departments, hospitals, social and welfare agencies, and the individual practising physician, will give a better understanding of the cause, transmission, and control of these diseases. This knowledge should change traditional attitudes and stimulate thought and examination of our present procedures in hospitalization of these patients. As was stated earlier in this paper the reason for hospitalization three centuries ago was to remove the patient from the community. Today the reason for hospitalization is to provide the best possible treatment and care. If this cannot be provided in the home, where today many patients with communicable diseases remain, then in what better place can the patient receive this care than in the general hospital, with its up-to-date over-all diagnostic and therapeutic facilities, operated by competent and adequate staff? ●

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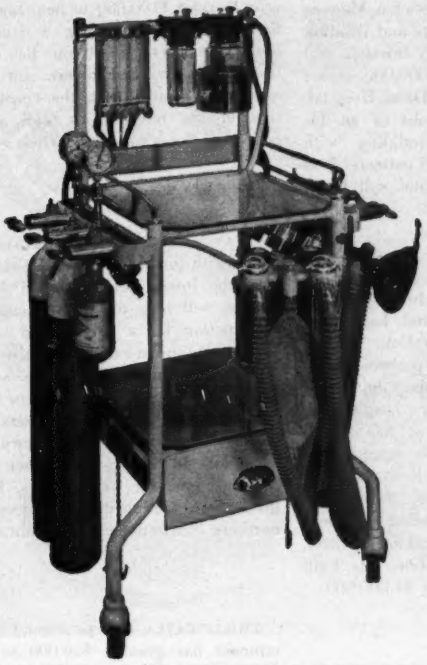

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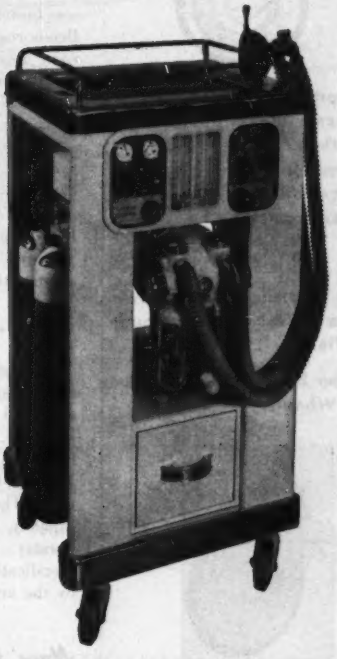

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Provincial Notes

(Concluded from page 74)

eral for the past four years, closed recently and it is expected that the new training program will be initiated shortly.

Quebec

MONTREAL. Demolition of a 100-yard square section, between Maisonneuve and Plessis streets and fronting on Sherbrooke St., early this fall, will clear space for the $7,000,000 expansion program of Notre Dame Hospital. The addition will consist of an 11-storey, cross-shaped building with accommodation for 300 patients. It is expected that the hospital will be in use by the end of 1953.

• • • •

MONTREAL. The new Julius Richardson Convalescent Hospital, located on Bessborough avenue at Cote St. Luc road, received its first patients at the end of July. Built to replace the former children's convalescent hospital at Chateauguay Heights, it has a bed capacity of 144 and is equipped to care for the needs of convalescent children. School-rooms have been provided and are staffed by both French and English speaking teachers. The five-storey institution was built at an estimated cost of $1,000,000.

• • • •

QUEBEC. Preliminary plans for a new Jeffrey Hale's Hospital have been approved and the proposed six-storey structure, with basement and sub-basement, will be constructed on an 11-and-a-half acre site on St. Foye road. The building will have a bed capacity of 146, with a 31-bassinet nursery. Working plans and detailed specifications are now being prepared by the architects.

New Brunswick

GRAND FALLS. Les Oblates Missionnaires de l'Immaculée have purchased the former Emard Hospital and are currently renovating the building. When the work is completed the hospital will have 26 adult beds, five to seven children's beds, and a 10-bassinet nursery. The institution, which serves Grand Falls, St. Andre, New Denmark, Drummond, and St. George, will be staffed by five graduate nurses, nurses' aides, as well as other personnel.

Newfoundland

BAIE VERTE. It is expected that a campaign will be launched within the year to raise $100,000 to help toward the cost of constructing a cottage hospital to serve the White Bay district. The provincial government will assist, financially, with the construction of the hospital, as well as a residence for a medical officer.

• • • •

ST. ANTHONY. Federal and provincial funds, with further financial assistance from the International Grenfell Association, will help toward the cost of construction for a new 50-bed sanatorium. A limited number of beds for tuberculosis patients have been available in a small building in the community for the past few years but recent health surveys have shown the need for an increased number. St. Anthony has, for many years, been the centre for medical services in northern Newfoundland and Labrador.

• • • •

TWILLINGATE. The provincial government has granted $50,000 to the Notre Dame Memorial Hospital to assist toward the building costs of a two-storey addition, with basement, which will measure 41 by 52 feet. A dental clinic will be established in part of the additional space.

Preparation for Poliomyelitis at "K-W" Hospital

The Kitchener-Waterloo Hospital, Kitchener, Ont., recently installed a respirator for the treatment of acute cases of poliomyelitis. As another important step toward adequate treatment of this disease, four nurses spent some time observing methods used in poliomyelitis care at the Toronto Isolation Hospital, Toronto, Ont. The respirator was given to the hospital by the Ontario Department of Health.

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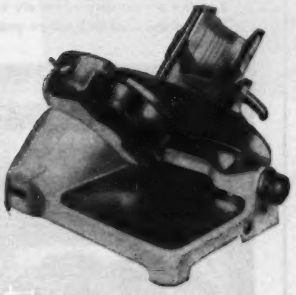

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Educating Rural Communities

(Concluded from page 43)

serving their hospital. They are our constant reminder that human relations and a spirit of service and self-sacrifice first led to the establishment of our voluntary hospitals. Let us not allow the seemingly more important economic trend to overshadow our original function. Women's auxiliaries are important missionaries in the field of one of our most democratic institutions, the hospital, which is dependent upon the public for goodwill and support.

It is a foregone conclusion that illness and death rates are higher in rural than in urban areas. Offsetting this gloomy picture, we are told authoritatively "that country-born, or their children, produce more leaders of men than do the succeeding generation of townsmen, and that the physical standards of the urban population deteriorate unless there is a constant infusion of fresh blood from the country".

Taking these two important facts into consideration makes us realize that if the urban centres are to survive with a degree of physical fitness and produce good leaders and if the death rate in rural areas is to be reduced, we must direct our program towards the rural area. There is an interdependence which is too valuable an asset to any country to be disregarded. It is time for clear thinking and careful planning.

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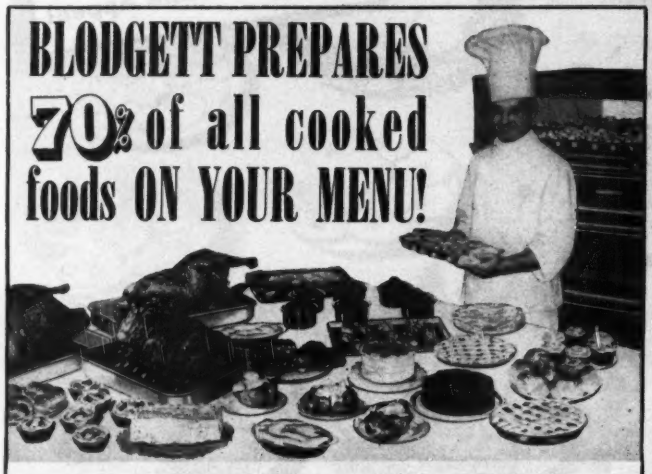

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Plant Bulbs Now

(Concluded from page 64)

for the bulbs. Holland became pre-eminent in the cultivation of tulips and to this day she supplies the bulbs for the gardens of the world. However, Turkey, where the flower originated, still has a strong affection for it since the tulip is the Turkish national flower.—*Courtesy, Edward Gottlieb and Associates, New York.*

Handle With Care for Safe Sawing

The safe handling of saws—whether they are key saws, coping saws, hack saws, or one of the many other varieties—is simplified when maintenance personnel know safe handling procedures. Here are suggestions of the State of New York Division of Safety for the safe handling of handsaws.

A handsaw should be sharp and the teeth properly set. A crosscut saw should be used for cutting the grain of the wood and a ripsaw for cutting with the grain.

When starting to cut it is advisable to take only one or two long slow cuts upward guiding the saw with the left hand. The saw should never be pulled back so far that it leaves the cut, as it may buckle and break, which may cause an injury to the worker. The hand should then be removed from the dangerous area and the sawing continued.

If the saw blade is kept in direct line with the cut, it will work more easily and the likelihood of sudden binding, which may throw the user off balance, will be reduced.

To use a hacksaw safely, grip the handle with the right hand and use the left to guide the saw. After use the saw should immediately be hung up and placed securely to eliminate danger of falling.—*Institutions Magazine.*

One ought to see everything that one has a chance of seeing; because in life not many have one chance and none has two.—*John Masefield*

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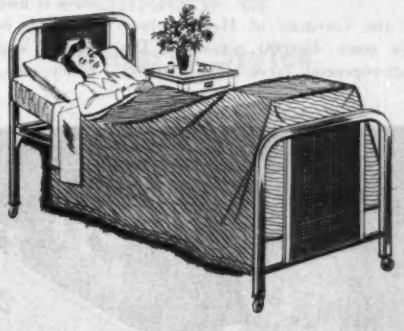

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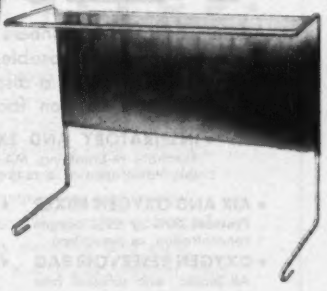

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Nutrition in Hawaii

(The following is an article by Elsie G. Watt, County Nutritionist, Kauai, Hawaii, which was published in Canadian "Nutrition Notes", June, 1952.)

IN the Territory of Hawaii, there are some 450,000 persons. The heterogeneous racial make-up of the population as well as the wide variation in activities and the differences in economic levels complicate the nutrition picture. Only seven per cent of the total land area of 4,099,840 acres is used for raising crops. Sugar, pineapple, coffee, cattle, milk products, poultry, eggs, hogs, fruits, vegetables, honey, nuts, and flowers are produced. As a result of industrialization, fewer families have their own gardens. The University of Hawaii, through its extension service, is doing much to encourage an increase in home production.

Each race had its own peculiar food habits and customs. Many of these were excellent from the point of view of nutrition but have been weakened considerably by the adoption of American and European foods. For example, the former Hawaiian diet of fish, poi, sea-weed, Hawaiian greens, and fruit is not enhanced by the addition of Oriental rice and American white bread, doughnuts, and pastries. The addition of these same foods by the Oriental ethnic groups to their diets has resulted in ones which are very high in carbohydrates and low in protein and other essential factors.

Many changes have been brought about in the health of the people since the initial establishment of a Board of Health in 1850. Tuberculosis was then and still is a public health problem. The Tuberculosis and Health Associations of Oahu, Maui, Hawaii, and Kauai, realizing the importance of good nutrition in protection against and in treatment of tuberculosis have, for the past five years, employed a nutritionist on each of the four larger islands. The nutritionist works through the Department of Health, under the Territorial Bureau of Nutrition which was established in 1947.

The nutritionists give both direct and indirect service by means of radio broadcasts, newspaper articles, nutrition talks illustrated by movies, filmstrips, posters, exhibits, and demonstrations. Literature produced by the Bureau of Nutrition and elsewhere is widely distributed. The nutritionists also act as consultants to the health department personnel and take an active part in in-service training, conferences, and institutes. They also act as consultants to the Department of Public Welfare and to any other organizations, institutions or individuals who seek information or assistance. The public health nurses and welfare workers help to augment the work of nutritionists through their contacts in the homes and in maternal and child health conferences.

Disaster food service planning is part of the work of several of the nutritionists. Lectures in nutrition to Red Cross groups are important contribu-

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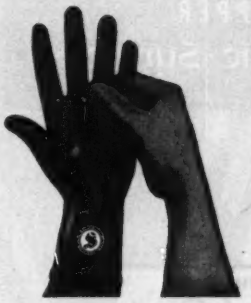

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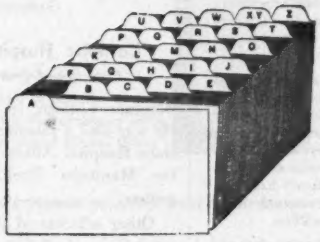

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tions to the total nutrition teaching programs.

Through nutrition studies, which include food intake records, dental surveys, and physical examinations, the need for improved nutrition for school children has been shown. The Kauai study on 144 children indicated a number of nutritional deficiencies. These included signs of rickets, conjunctivitis, dry hair, poor muscle tone, as well as a general mild anaemia and some skin conditions, ear infections, and much overweight and underweight.

Talks to parent-teacher associations and mothers' groups are used as a means of increasing the awareness of existing problems and methods for their solution. More investigation is still needed.

Through radio interviews with local producers of food, increased use of local products is encouraged whenever possible and advisable. These have been a part of the Kauai nutritionist's weekly radio series and have indicated that much more food could be produced and sold on the Islands. Local fruits that are very high in vitamin C for instance, are often ignored and replaced by mainland apples and pears.

The lack of sufficient milk in the diets is one of the weak points and emphasis is being placed on its wider use. Evaporated milk is stressed as the most economical and readily available form and powdered skim milk is recommended as an addition to the diets. Increased use of local fish, vegetables, and fruits, is recommended constantly as well as increased use of whole grain cereals. Enrichment of white flour and white bread is in force but no action has yet been taken on recommendations that rice be enriched. One hundred per cent pasteurization of milk by all dairies has not yet been achieved except on the Island of Kauai. However, Oahu has 98 per cent pasteurization and the Island of Hawaii more than 50 per cent. Control over the herds supplying milk to the dairies is maintained.

Conferences between the nutritionists have been held at infrequent intervals but plans were made in September 1951 to hold quarterly meetings. In this way it is hoped to co-ordinate and strengthen the nutrition program in the territory.

There is a tremendous effort being made, too, through health councils, to correlate the work of all the health agencies, whether government controlled or voluntary. With this spirit of co-operation the "melting-pot" of the Pacific cannot fail to accomplish more in the future.

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Catholic Hospital Council

(Concluded from page 59)

Boniface College, St. Boniface, Man. He was also a member of the St. Boniface Hospital Advisory Board and of the Manitoba Health Survey Committee.

Other officers of the Catholic Hospital Council of Canada for the year 1952-53 are as follows:

First Vice-President: Mother M. Mann, 1190 Guy Street, Montreal, P.Q.

Second Vice-President: Sister Beatrice, St. Michael's Hospital, Lethbridge, Alta.

Secretary: Mother Margaret, St. Michael's Hospital, Toronto.

Treasurer: Sister Joseph Edmund, Ottawa General Hospital, Ottawa.

Additional Executive Officers: Mother Superior, Hotel Dieu, Windsor, Ont., Sister Pulcheria, St. Elizabeth's Hospital, Humboldt, Sask.

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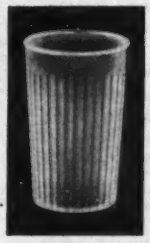

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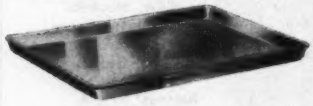

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C.S.R.T. Elects Officers

At the conclusion of the annual convention of the Canadian Society of Radiological Technicians, held at the Palliser Hotel, Calgary, Alta., from September 3-6, E. P. Hunt of Regina, Sask., was elected president. He succeeds W. Q. Stirling of Vancouver, the retiring president, who was elected vice-president. Mrs. E. I. Hood of Vancouver, was re-elected secretary-treasurer. The next convention will be held in June, 1953, in Toronto.

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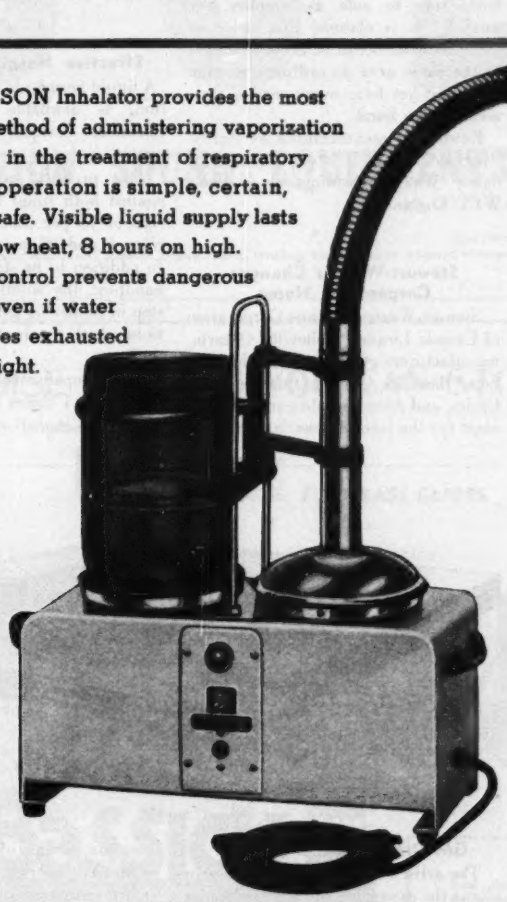

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"Appealing for funds to pay off a debt for hospital facilities already existing rather than for funds to provide additional facilities is one of the most difficult tasks faced by any hospital," Mr. Lawson explained. "Yet that was the situation at Charlottetown Hospital which built a new wing about six years ago with borrowed money because an appeal to the community was not feasible at the time.

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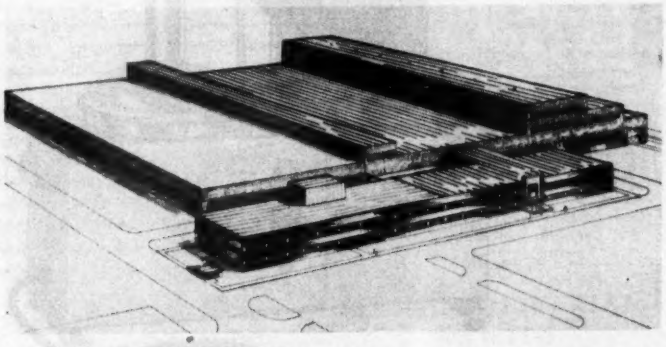
Effective Hospital Germicide

A liquid germicide, Santophen 1 Solution, is available from Monsanto Chemical Company in commercial quantities.

The product, which is effective against both fungi and bacteria, consists of 75 per cent by weight Santophen 1 and 25 per cent isopropanol. In addition to its stability and ease of handling, the solution eliminates one step in preparing germnicidal formulations which involve the use of isopropanol.

The company will continue to offer Santophen 1 flakes for those who pre-

(Concluded on page 128)



GM Diesel Plant Expansion

The artist's sketch reproduced above shows the expansion of General Motors Diesel Limited, London, Ontario, in the past two years. The darker shaded portion at the right, office building in front and the big plant at the rear, was the original construction. Continuation of the office building, left, is the Engineering and Development Centre completed in 1951. At the left rear and shown in white, is the latest projected addition, to cost $2,500,000.

GM Diesel stand-by power units for hospitals is included in the equipment manufactured in the London plant.

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Head Office: 4040 St. Catherine St. West, Montreal, Que.
Branches at: Halifax, Saint John, Quebec, Montreal, Ottawa, Toronto, Winnipeg, Regina, Calgary, Edmonton, Vancouver.

DS-52-1E

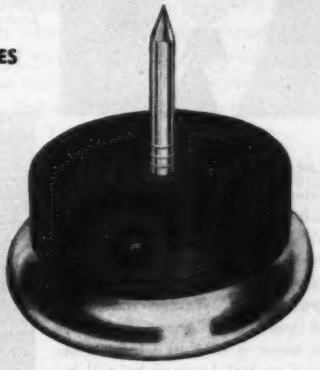
NOISE ANNOYS! YOU CAN STOP IT! WITH

Bassick FLAT BASE GLIDES

Cut ward clamour and save floor wear by using Bassick Rubber Cushion Glides.

Easy to apply. Types to fit all wood and metal chairs and desks.

Bassick Rubber Cushion glides assure quiet, easy gliding floor protection, thanks to their heavy gauge, fully hardened, highly polished, nickel plated steel base and live rubber cushion.



MAKING MORE KINDS OF CASTERS
MAKING CASTERS DO MORE

Bassick SW
DIVISION
STEWART-WARNER CORPORATION
of Canada, Limited
BELLEVILLE ONTARIO

And Bassick has the caster to do the job for you. Easier swivelling, longer lasting. Floor protecting too.

Across the Desk

(Concluded from page 126)

fer the 100 per cent active material. A germicide of substituted phenolic composition, Santophen 1 shows phenol coefficients in the order of 150 to 200 against standard test organisms, and kills fungi in concentrations of .005 to .05 per cent. It is non-irritating in usage dilutions and relatively non-toxic to higher animals, according to company tests.

Santophen 1 has been formulated for a variety of purposes, including sanitizing restrooms, disinfecting floors, walls and equipment in hospitals, deodorizing garbage cans, and treating locker rooms and swimming pool premises for the control of athletes foot.

* * *

Lac-Mac Representative

Lac-Mac Limited announces the appointmen tof Mr. William M. Crago, as Ontario Sales Representative, for their complete line of hospital textile products, uniforms and nurses' capes. He was formerly with Textile Industries Limited and Ella Skinner Uniforms and his home is in Port Credit, Ont. From this central location he will be regularly servicing all Ontario hospitals.

* * *

Introduces New Battery Cap

Dominion Diesel, Ltd., Toronto, has been named exclusive Canadian representative of Industrial Research Inc., Miami, Florida, research and development company. The Toronto company, located at 63 Yorkville Avenue, will handle Industrial Research Inc.'s new products, Hydrocap, a revolutionary new battery cap which preserves the water in batteries, prevents corrosion and warns of overcharge.

The new cap contains a catalyst which converts a battery's escaping hydrogen and oxygen gases back into water. Hydrocaps are sold in a set of three and are designed to replace the battery's conventional caps. They are available in all sizes to fit any make of battery. Retailing at $3.95 for a set of three, they require no refilling or any type of adjustment after the initial installatoin and will last indefinitely. According to the manufacturers, they will add anywhere from six months to a year and a half to the usable life of the average car battery.

Hydrocaps have a very special application in hospitals for batteries that start emergency lighting and power plants, and those for emergency operating room lights.

* * *

New Television Line

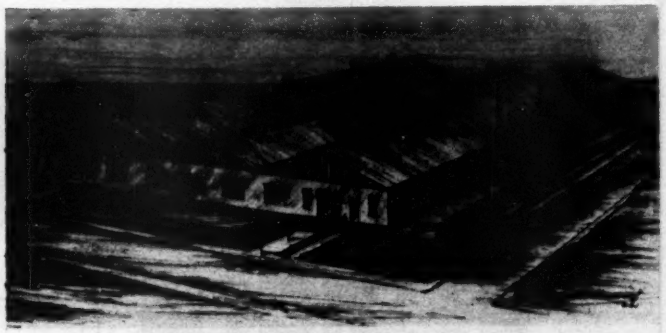
Rogers Majestic Radio Corporation's new television line for 1952-53 is now on display. These new receivers have been expressly designed for the Canadian TV market. Every known advance has been incorporated in their beautifully designed cabinets. Synchronized sight and sound is an exclusive feature in the table models, made possible by the speaker being mounted in the front of the receiver. The Electro-static Tube and Cascade Tuner are two of many advances that produce a picture of unmatched richness, brilliance and clarity. Available in 17" and 21" screens, these Rogers Majestic models are strikingly designed in three hand rubbed veneers of walnut, mahogany and oak.

* * *

How To Select Personnel

The manager was thoroughly sold on the use of psychology for selecting personnel, so he called in a psychologist to help him interview three applicants for secretary.

"What do two and two make?" the psychologist asked the first. "Four," was the prompt answer. To the same question the second girl replied: "It might be 22." The third girl answered: "It might be 22, and it might be four." When the girls had left the room the psychologist turned triumphantly to the manager. "There," he said, "that's what psychology does. The first girl said the obvious thing. The second smelled a rat. The third was going to have it both ways. Now which girl will you have?" The manager did not hesitate. "I'll take the blonde with the blue eyes," he said.



New Crane Limited Calgary Plant

An artist's impression of the new Crane Limited plant which will be built in Calgary for the manufacturing of valves and fittings is shown above. Over 50,000 square feet of floor space will provide for present needs and allow for future expansion. It will contain the most up-to-date manufacturing facilities and it is hoped that production can be started before next summer.

Penicillin Sterile Dressings

Sterilized Non-Adherent Gauze Net Dressing *with Penicillin*

Penicillin Nonad Tulle is a gauze net of wide mesh impregnated with an emulsifying base containing 1,000 I.U. of Penicillin per gramme, equivalent to 160 I.U. penicillin per square inch of Tulle.

For use as a protective dressing to infected wounds and burns and as a first dressing following operations.

Supplied in sterile tins each containing 10 pieces 4″ x 4″, and in continuous strips 72″ x 4″.

Also Nonad Tulle available as sterile dressing *without penicillin* in following sizes: 2″ x 2″; 4″ x 4″; 6″ x 6″; continuous strip 4″ x 72″ and 3 continuous strips 4″ x 72″.

Complete literature on request.

A-152X

THE ALLEN AND HANBURYS COMPANY LIMITED
TORONTO, ONT. LONDON, ENG.

SAVE WORK!

C-I-L SPONGES

clean faster... easier... better

For practically every cleaning job, C-I-L SPONGES are money and work-savers. Use them for washing windows, walls, woodwork . . . tile work, kitchen and bathroom fixtures . . . table-tops, counters, etc. Excellent for dishes, glassware, pots and pans.

C-I-L SPONGES are tough and durable, yet velvet-soft when wet. They can stand the wear and tear of rough surfaces, but won't scratch or mar the finest finish. They're free from grit and other impurities and easily sterilized after using.

Hold 20 times their weight in water

C-I-L SPONGES are amazingly absorbent, yet even when saturated they *float*—don't pick up dirt from bottom of cleaning pail. Their flat surfaces cover more area, square shape makes it easier to get into corners.

Cut cleaning expense by using low-cost, long-wearing C-I-L SPONGES. Available in 6 handy sizes.

Order from your supplier

B-752-H

CANADIAN INDUSTRIES LIMITED

Tune in to C-I-L "Singing Stars of Tomorrow", Sunday Evenings, Dominion Network.

C-I-L Sponges

Index of Advertisers

OCTOBER, 1952

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Council, 57 Bloor Street West, Toronto 5.

NURSING AIDES' UNIFORMS

Smart! Practical! Long-Wearing!

Specially designed for Hospital use ..

Created especially for hospital use, these distinctive uniforms by Corbett-Cowley provide the ideal dress where smartness, practical design and serviceability are the principal factors governing choice.

Choice of Colours

Corbett-Cowley uniforms for Nursing Aides, Waitresses and Maids are available in single colours or in a combination of colours—including various shades of blue, greens, maize, beige, brown, white, etc. Made from finest cotton suiting, with full allowance for shrinkage. Special styles made up to customer's specification. Standard size range: even bust measurements 32-44. Outsize to special order. Delivery on all orders: 3-4 weeks.

6009. Princess style and smartly designed checked collar and cuffs mark this as a particularly attractive model. Uniform includes head piece to match.

6008. A full Princess effect with the ever stylish puffed sleeve. Tailored collar is neat and attractive. Smart full skirt is always popular. Uniform includes head piece to match.

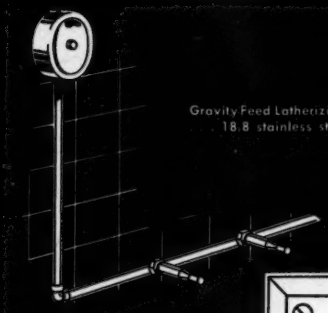
6010. An outstanding model where a plain but tailored effect is desired. Smartly pointed collar and cuffs lend a dignified appearance. Even sizes 32-44. Aprons and head bands are available, on order.

Sales Tax added to billings unless orders are accompanied by Regulation Sales Tax Exemption Certificate.

CORBETT-COWLEY
Limited

2738 Dundas St. W., Toronto 9
424 St. Helene St., Montreal 1

We look forward to seeing you at the
Ontario Hospital Ass'n
CONVENTION, TORONTO
OCT. 27 - 28 - 29
See us at Booth No. 26



Gravity Feed Latherizing Soap Systems. 18.8 stainless steel valves.

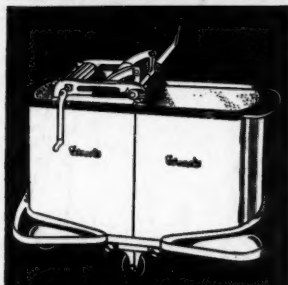
Chrome-plated Lathurn Liquid Soap Dispenser with 18.8 stainless steel valves provides a rich creamy lather.

No. 91 Liquid Soap Dispenser. Leak-proof; equipped with stainless steel valves.

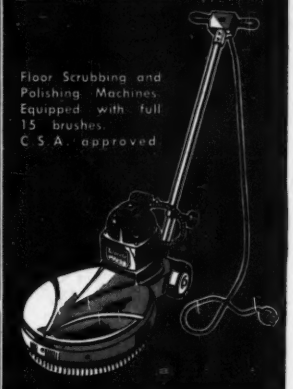
No. 94 Liquid Soap Dispenser. Leak-proof; pump action; delivers a measured quantity of soap as required.

Specify GH Wood's SANITATION EQUIPMENT

- **The best equipment for maintaining buildings in the most modern, sanitary manner.**
- **Wood's has 24 branches from coast to coast and 135 sanitation salesmen.**
- **May we submit specifications and quotations?**



Mop Trucks and Floor Maintenance Equipment. This Mop Truck is entirely self-contained; two 22½ gallon tanks.



Floor Scrubbing and Polishing Machines. Equipped with full 15 brushes. C.S.A. approved.

Self-closing, Fire-proof Waste Receptacles (with or without paper towel dispensers.) Various types and sizes.

Wood's Registered Deodorizers will positively re-condition the air in public toilets and washrooms.

Wood's Electric Water Cooler. Automatic thermostatic control assures constant supply of cool water.

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